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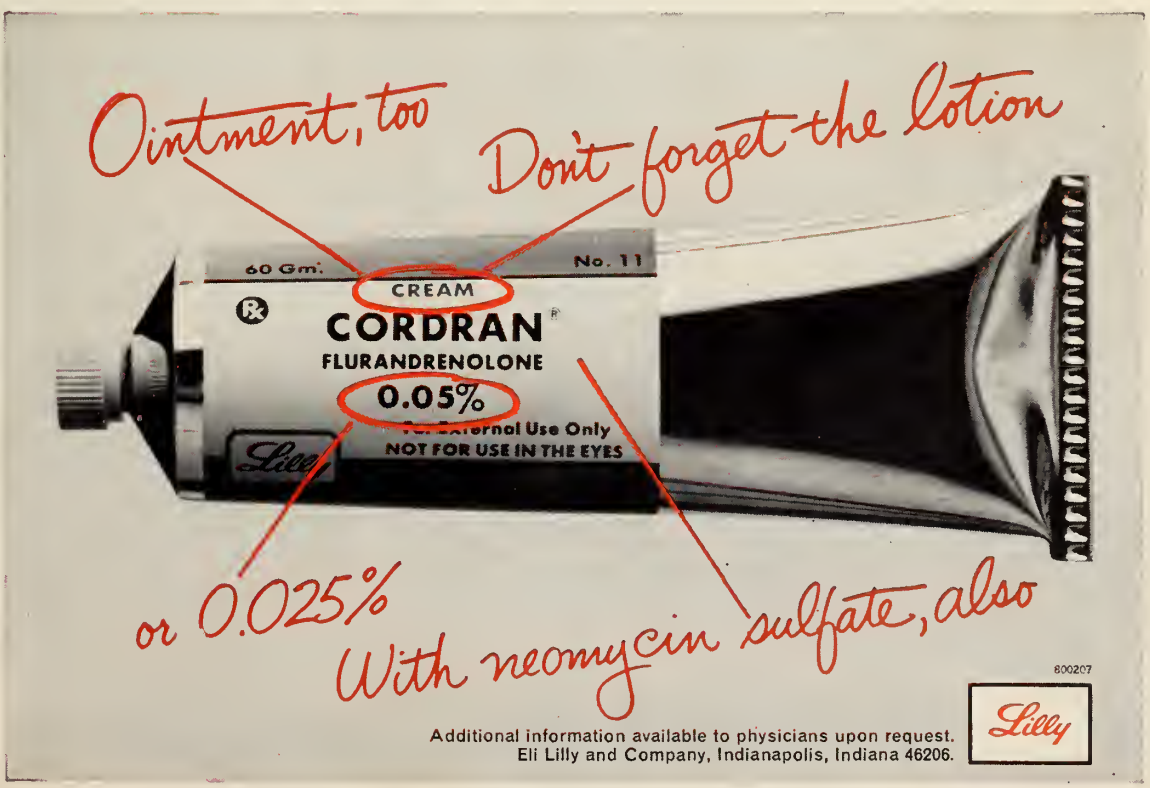
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JOURNAL of the Medical Association of the State of ALABAMA

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22 JUL 1968

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JULY 1968



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Warnings: Acute anaphylaxis (may prove fatal unless promptly controlled) is rare but more frequent in patients with previous penicillin sensitivity, bronchial asthma or other allergies. Resuscitative (epinephrine, aminophylline, pressor amines) and supportive (antihistamines, methylprednisolone sodium succinate) drugs should be readily available. Other rare hypersensitivity reactions include nephropathy, hemolytic anemia, leucopenia and thrombocytopenia. In suspected hypersensitivity, evaluation of renal and hematopoietic systems is recommended.
Precautions: In suspected staphylococcal infections, perform proper laboratory studies including sensitivity tests. If overgrowth of nonsusceptible organisms occurs (constant observation is essential), discontinue penicillin and take appropriate measures. Whenever allergic reactions occur, withdraw penicillin unless condition being treated is considered life threatening and amenable only to penicillin. Penicillin may delay or prevent appearance of primary syphilitic lesions. Gonorrhea patients suspected of concurrent syphilis should be tested serologically for at least 3 months. When lesions of primary syphilis are suspected, dark-field examination should precede use of penicillin. Treat beta-hemolytic streptococcal infections with full therapeutic dosage for at least 10 days to prevent rheumatic fever or glomerulonephritis. In staphylococcal infections, perform surgery as indicated.
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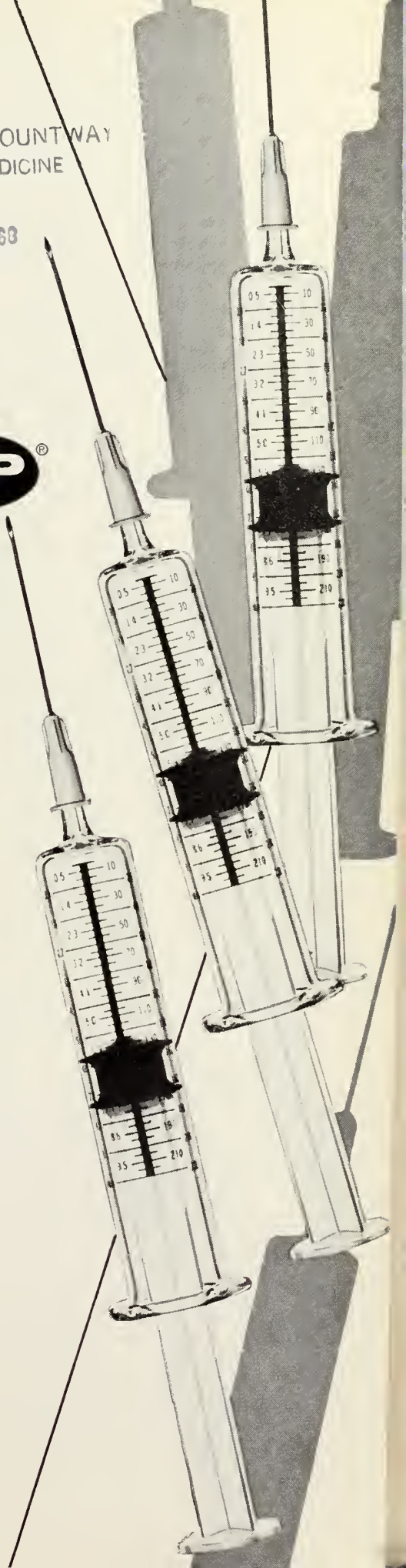
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of the

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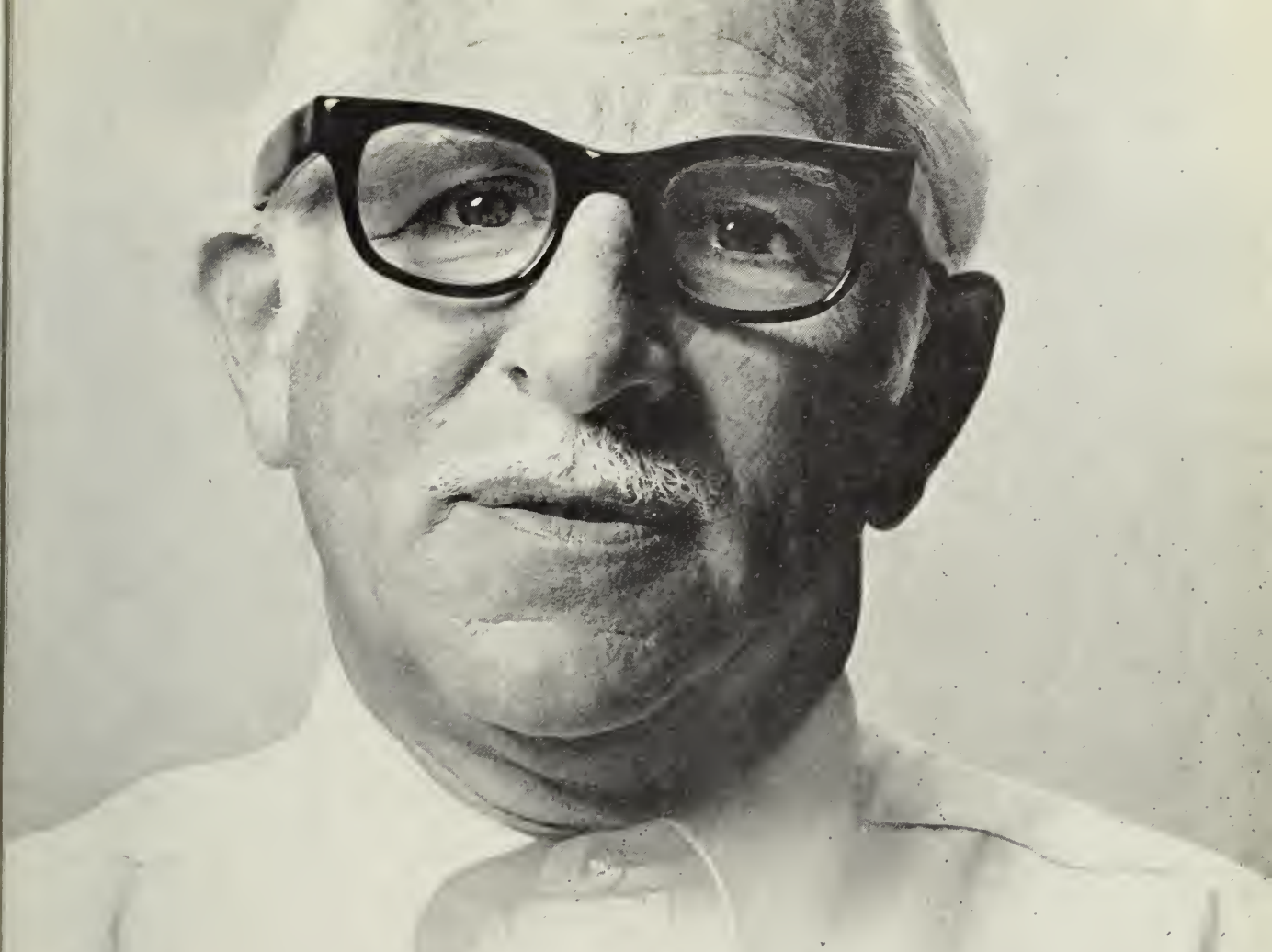
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utions: Overgrowth of nonsusceptible organisms may occur. Con- stant observation is essential. If new infections appear, appropriate measures should be taken.

In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, food and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

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A Resolution

Lurleen Burns Wallace

Governor of Alabama

January 16, 1967—May 7, 1968

WHEREAS, The Great Physician, in His infinite wisdom, has seen fit to summon from our midst the gracious lady who occupied the exalted office of Governor of the State of Alabama; and

WHEREAS, Lurleen Burns Wallace rose from the humblest station in life to become the Chief Executive of this State, beloved by the citizens thereof to a degree unparalleled throughout this nation; and

WHEREAS, in her capacity as Governor of Alabama, the Honorable Lurleen Burns Wallace was ex-officio chairman of the State Board of Health; and

WHEREAS, Lurleen Burns Wallace, during the brief span of her service to this State, exhibited a rare and compassionate concern for the mentally and physically stricken of her constituency; and

WHEREAS, during her tenure she devoted more of her attention and efforts to relieving the sick and distressed than any other Governor in the history of this State; and

WHEREAS, her own stamina and courage were exhibited in the face of overwhelming physical adversities; and

WHEREAS, during the entire time of her government career she exhibited deep faith and abiding trust in the physicians of this State and all other conservators of the public health, as well as those responsible for ministering to the afflicted; and

WHEREAS, Lurleen Burns Wallace in her roles of private citizen, wife, mother, and public official demonstrated the Christian qualities which will make her name revered in the history of the State of Alabama; and

WHEREAS, her death will prove a grievous loss to the medical and paramedical professions and all others who benefitted from her precept and example;

NOW, THEREFORE BE IT RESOLVED, that the Board of Censors of the Medical Association of the State of Alabama, the State Committee of Public Health and the State Board of Medical Examiners does hereby express its grief over the death of our beloved Governor and true friend; and be it further

RESOLVED, that these Boards do extend to the Honorable George C. Wallace and the children of Lurleen Burns Wallace its deepest sympathy in the loss of their wife and mother, and its appreciation for having had the opportunity to know and be associated with this great lady in many of her humanitarian enterprises; and be it further

RESOLVED, that this Resolution be spread upon the minutes of the Board of Censors of the Medical Association of the State of Alabama, the State Committee of Public Health, and the State Board of Medical Examiners as testament of the love and esteem which the members thereof held for the Honorable Lurleen Burns Wallace; and be it finally

RESOLVED, that a copy of this Resolution, suitably inscribed, shall be sent to the Honorable George C. Wallace and his family, and that it be published in The Journal of the Medical Association of the State of Alabama for the information of all physicians of this State.

Adopted at Montgomery, Alabama on the 15th day of May, 1968.

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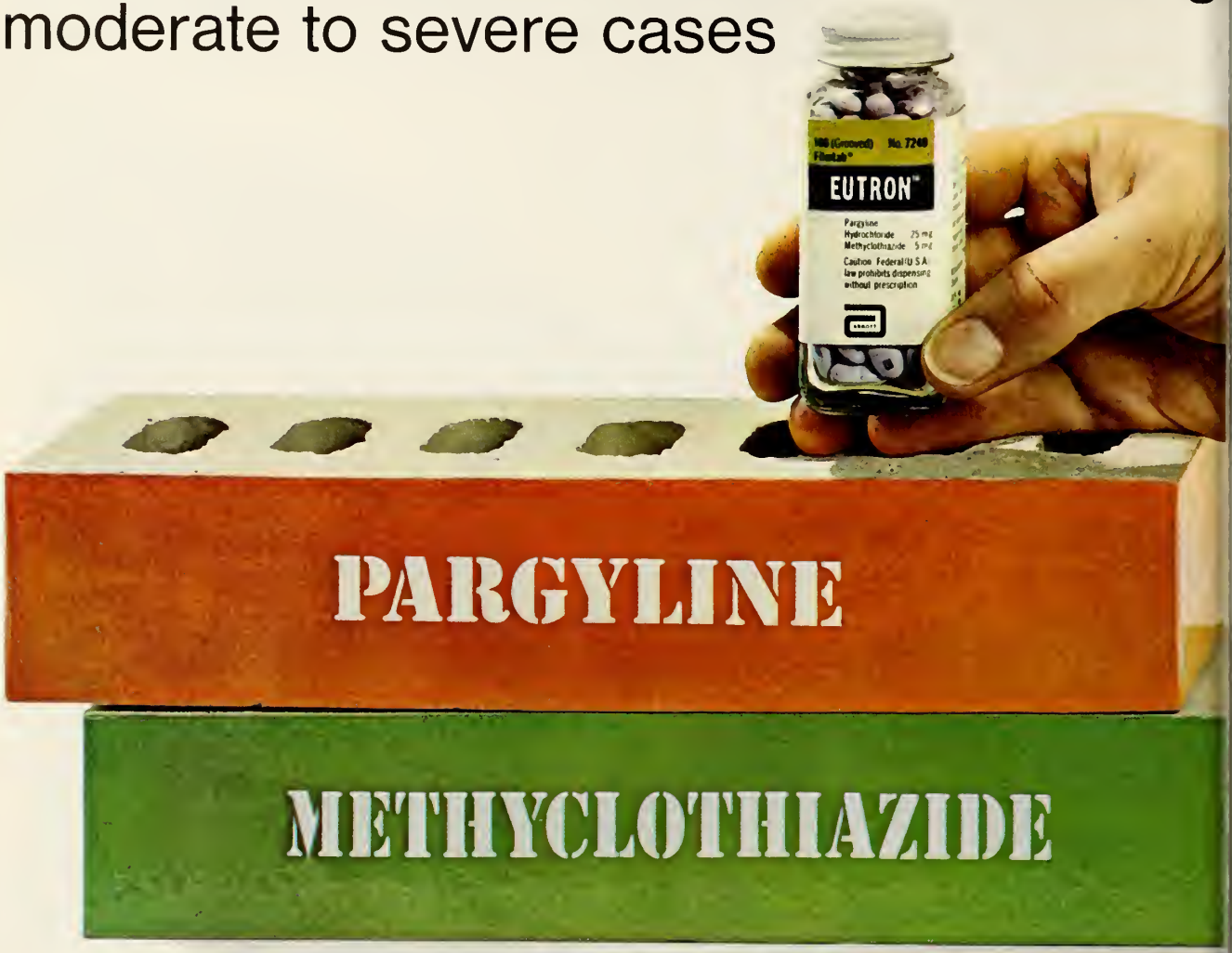
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Contraindications: Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease or impending hepatic coma (hepatic coma due to hypokalemia has been reported in patients on thiazides). Do not use Enduronyl in severe mental depression, suicidal tendencies, active peptic ulcer, or ulcerative colitis.

Warnings: Consider possible sensitivity where there is history of allergy or asthma. If added potassium is indicated, dietary supplementation is recommended. Reserve enteric-coated potassium tablets for cautious use only when necessary, as they may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation often requiring surgery; discontinue them immediately if abdominal pain, distention, nausea, vomiting, or g.i. bleeding occurs. Neither Enduron nor Enduronyl contains added potassium.

Precautions: Use thiazides cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery, thiazides may reduce response to vasopressors, and increase response to tubocurarine. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia) in all patients. In hypokalemia (especially in digitalized patients) give supplemental potassium. In hypochloremic alkalosis, give supplemental chloride.

Use rauwolfias with caution in patients with history of peptic ulcer. Rauwolfias with anesthetics may produce hypotension and bradycardia. Discontinue Enduronyl two weeks before elective surgery. Consider vagal blocking agents during emergency surgery. In epilepsy, adjust anticonvulsant dosage. In electroshock, shorten stimulus strength and duration. In occasional patients with depressive tendencies, rauwolfias may precipitate severe mental depression that usually disappears when drug is stopped.

Adverse Reactions: Thiazide reaction include blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, serum uric acid or blood sugar; anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, symtomatic gout, and pancreatitis. Cutaneous vasculitis in the elderly has been reported with other thiazides. Adverse effects with deserpidine are qualitatively similar to those with reserpine, but their incidence is lower. These include nasal stuffiness, abdominal cramps or diarrhea, nausea, headache, weight gain, reduced libido and potency, peptic ulcer aggravation, epistaxis, skin eruption, asthma in susceptible patients, electrolyte imbalance, excessive salivation, and a reversible Parkinson's syndrome. Excessive drowsiness, fatigue, weakness, and nightmares may signal mental depression. Thrombocytopenia, purpura, and a symptom manifested by dull sensorium, deafness, uveitis, glaucoma, and optic atrophy are rare allergic reactions to other rauwolfias. Hypotension from antihypertensive agents may precipitate angina attacks in susceptible individuals. Usually adverse reactions disappear when drug is withdrawn.

EUTRON™

Each tablet contains Pargyline Hydrochloride 25 mg. with Methyclothiazide 5 mg.

Indications—Moderate to severe hypertension.

Contraindications—Pheochromocytoma, paranoid schizophrenia, hyperthyroidism and advanced renal failure. Not recommended in malignant hypertension, children under 12, pregnant patients.

Do not use with: centrally or peripherally acting sympathomimetic drugs; foods high in tyramine (e.g., aged and natural cheeses); parenteral reserpine or guanethidine; imipramine, amitriptyline, desipramine, nortriptyline or their analogues; other monoamine oxidase inhibitors; methyldopa or dopamine; separate Eutron and these agents by two weeks.

Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease; impending hepatic coma from thiazide-induced hypokalemia.

Warnings—Patients: 1. No other drugs (particularly "cold preparations" and antihistamines), cheese or alcohol without physician's consent. 2. Promptly report orthostatic symptoms, severe headache, other unusual symptoms. 3. Angina pectoris or coronary artery disease patients must not increase physical activity with improved anginal symptoms or well-being.

Physicians: 1. Use antihistamines, hypnotics, sedatives, tranquilizers and narcotics (meperidine contraindicated) cautiously in reduced doses. 2. Stop Eutron two or more weeks before elective surgery; in emergency surgery reduce premedication (narcotics, sedatives, analgesics, etc.) to 1/4 to 1/5; carefully adjust anesthetic dosage to patient response. 3. Use cautiously in advanced renal failure. 4. Pargyline may induce hypoglycemia. 5. Consider possible sensitivity reactions when a history of allergy or asthma is present. 6. If potassium is indicated, dietary supplement is recommended; enteric-coated potassium tablets may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation frequently requiring surgery; discontinue medication immediately if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs; Eutron does not contain added potassium. 7. Possible systemic lupus erythematosus has been reported for thiazides.

Precautions—Pargyline: Use cautiously at reduced dosage: caffeine, alcohol, antihistamines, barbiturates, chloral hydrate, other hypnotics, sedatives, tranquilizers, narcotics. Periodically do urinalyses, blood counts, liver function tests, etc. Use with caution in liver disease. Watch for orthostatic hypotension, especially in impaired circulation (e.g., angina pectoris, coronary artery disease, cerebral arteriosclerosis); also, augmented hypotension in concomitant febrile illnesses. Reduce or discontinue if hypotension is severe. In impaired renal function watch for cumulative drug effects, elevated BUN and other evidence of progressive renal failure; withdraw drug if these persist. In surgery increased central depressant response (hypotension and increased sedative effect) can be controlled by (1) discontinuing at least two weeks prior; (2) in emergency surgery lowering dose of premedication; (3) when necessary, administering a vasopressor. Do not use in hyperactive and hyperexcitable patients. Pargyline may unmask severe psychotic symptoms where emotional problems pre-exist. Use cautiously in Parkinsonism, especially with antiparkinsonian agents. In prolonged therapy, examine for change in color perception, visual fields, fundi and visual acuity. Also, prolonged therapy has made certain patients refractory to nerve blocking effects of local anesthetics.

Methyclothiazide: Use cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery thiazide may reduce vasopressor response and increase tubocurarine response. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia). Give supplemental chloride if hypochloremic alkalosis occurs and supplemental potassium if hypokalemia occurs (especially in digitalized patients). Thiazides may decrease serum P.B.I. without signs of thyroid disturbance.

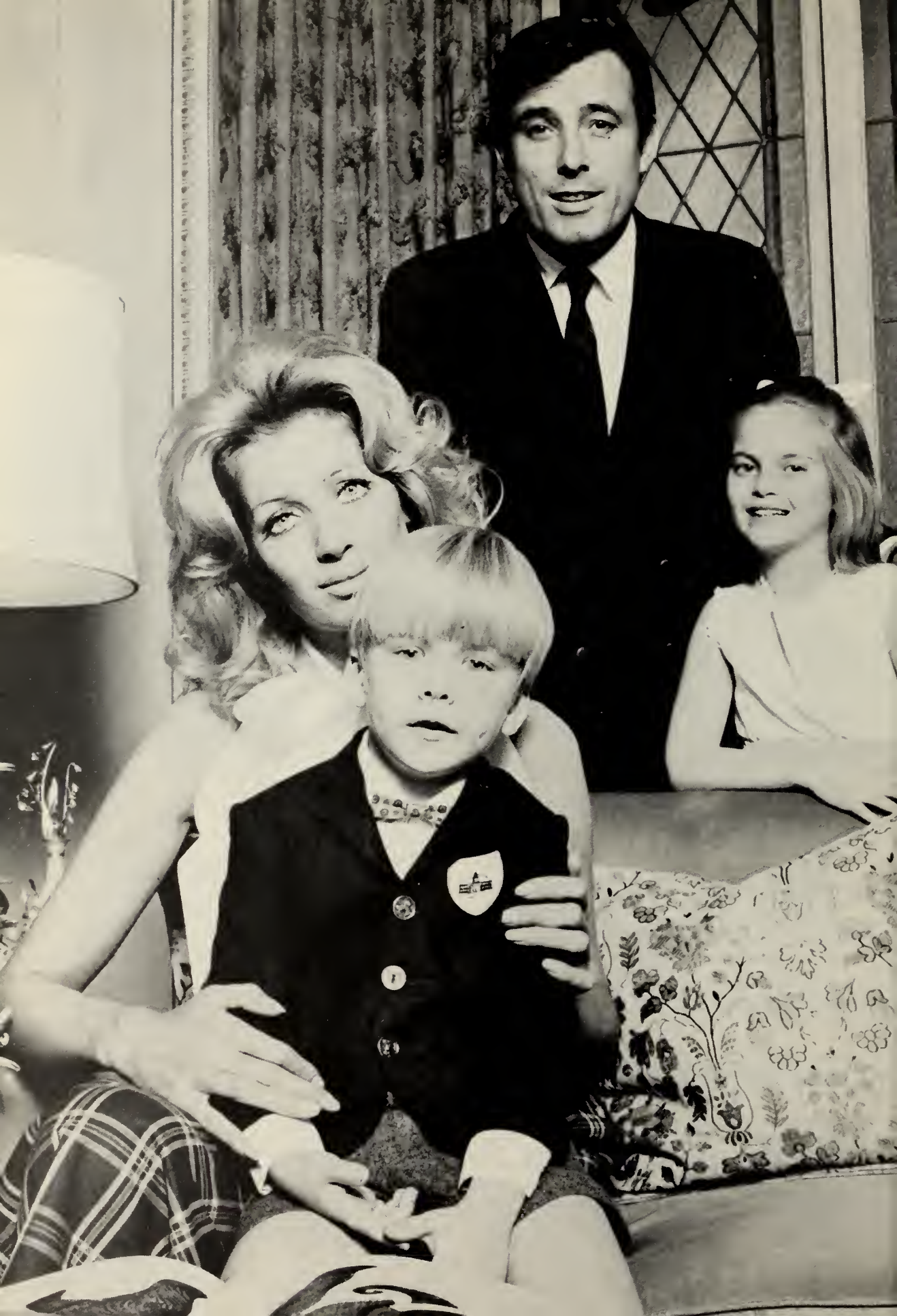
Adverse Reactions — Pargyline: Orthostatic hypotension and associated symptoms, mild constipation, fluid retention, edema, dry mouth, sweating, increased appetite, arthralgia, nausea, vomiting, headache, insomnia, difficult in micturition, nightmares, impotence, delayed ejaculation, rash, purpura, weight gain, hyperexcitability, increased neuromuscular activity and other extrapyramidal symptoms. Drug fever is extremely rare. Reduction in blood sugar and hypoglycemic effects are possible. Congestive heart failure has been reported in a few patients with reduced cardiac reserve.

Methyclothiazide: Blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, blood sugar or serum uric acid (gout may be induced); anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice and pancreatitis. Cutaneous vasculitis in elderly patients has been reported with other thiazides.

If side effects are severe or persist, reduce dosage or withdraw drug. 804438R

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President's Page



E. L. McCafferty, Jr.

It is a great pleasure for us to see the unusual abilities of our friends recognized and appreciated and for this we congratulate Bob Ingram on having been selected Finance Director for the State of Alabama. We wish for him all of the satisfactions that an appointment of these responsibilities can bring.

It is with regret that we learn of Bob's leaving our employ, for during the past 18 months he has made a contribution to the medical profession through his advice and counsel that will influence all of us over the years to come and which we believe will make the MASA a stronger and more effective organization. He has shown us a path of progress that I believe we will do well to follow—and for this we are grateful that Bob was a part of our organization.

Personally, I will miss the frequent contacts with Bob which I have enjoyed over the past months for he is truly a gentleman in every sense of the word; kind, considerate, responsible, and above all he gave himself untiringly to the best interests and welfare of the doctors in this state.

I wish that I could hope that someday in the future we could expect Bob to return; however, since life often shapes unexpected destinies for us we can be thankful he has passed our way and wish him every success and joy in his new career.

* * *

Another problem which the Medical Association is constantly facing is the continuing increase in the use of narcotics. Our State Health Department has established a special bureau of investigators to tract down violators of our narcotic laws. We have passed new laws in Alabama, and in Washington, to redefine narcotics violations and make the punishment more stringent.

Seldom does a month pass when some Alabama physician is not called before the State Board of Medical Examiners to explain his excessive prescribing of narcotic drugs. It is safe to assume that enforcement of the narcotic laws will become more strict and punishment more certain in the years ahead.

I would warn every member of the health team to be very careful in the handling, dispensing and recording of narcotics supplies than they have ever been before. For the physician this is an ethical as well as a criminal offense. For the other health professionals violation of the law can result in jail sentences or fines.

E. L. McCafferty Jr.

The Woman's Auxiliary

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WAMASA Editor, Mrs. William L. Smith

AUXILIARY PLEDGE

"I pledge my loyalty and devotion to the Woman's Auxiliary to the American Medical Association. I will support its activities, protect its reputation and ever sustain its high ideals."

I have had the privilege of attending the Annual Meeting of the Alabama Association for Mental Health recently. It was held in Huntsville on May 9 and 10, and was most informative and interesting. It was a pleasure to renew old acquaintances, and to make new friends, interested in this, one of our greatest concerns and challenges. We are indeed fortunate to have the excellent leadership in this field that we have in this state, and great plans are being made for the Mental Health program and activities for the months ahead.

On May 19, I attended my first Rural Health Conference in Montgomery, and found this to be interesting and helpful, also. The plans for the second Annual meeting, which will be held in August, were discussed, and this promises to be a very fine meeting, with outstanding people featured on the program.

At the present time, I am looking forward to another meeting, the National Convention in San Francisco, June 16-20. Several of the Auxiliary members plan to attend, and I am sure we will return with renewed enthusiasm, and that we will be better informed, better prepared to take up our tasks for the coming year.

While riding home from Montgomery last Sunday, I found myself thinking of time, and its importance. Time is precious, it is fleeting, and it is given in equal portions to each of us. Some of us use it well, others abuse it. It is so easy to become involved in too many activities in the days in which we live. It is well for us to take stock of our use of time, occasionally, and to evaluate it honestly, being sure that our minutes and hours are being utilized to the best advantage.



Mrs. Robert K. Wilson, Sr.

Another thing that crossed my mind while I was traveling was that the changes in the world have brought about many changes in the practice of medicine, in the life of the doctor and his wife and family. Adjustments have had to be made, and more will have to be made in the days ahead. Some things, however, never change, and these we need to remember: Integrity . . . . Compassion . . . . Courtesy . . . . Idealism . . . . Love . . . . God.

Louise M. Wilson

Mrs. Robert K. Wilson, Sr.
President, WAMASA

Open-eyed nights





Too tense to sleep...too tired to get up. Early to bed, late to rise, and not much sleep at that, the patient with severe psychic tension is understandably tired. His tensions and overreactions to the day's stresses may interfere with proper sleep, and his inability to face the day's activities can produce an ever-worsening pattern. By relieving psychic tension, Valium® (diazepam) facilitates sleep, particularly with an h.s. dose. In many patients, the usefulness of Valium has been demonstrated in relieving psychic tension alone or with secondary depressive symptoms. Valium is generally well tolerated and, with proper maintenance dosage, usually does not unduly impair mental acuity or ability.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in: skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders; athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindications: Known hypersensitivity to drug; children under 6 months of age; acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in treatment of psychotic patients, and should not be employed in lieu of appropriate treatment. As with most CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increase in dosage of standard anticonvulsant medication; abrupt withdrawal in such cases may also be associated with temporary increase in frequency and/or severity of seizures. Advise patients against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance. Keep addiction-prone individuals (such as drug addicts or alcoholics) under careful surveillance because of their predisposition to habituation and dependence. Use of any drug in pregnancy, lactation or in women of childbearing age requires that potential benefit be weighed against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, carefully consider individual pharmacologic effects —particularly with known compounds which may potentiate action of Valium (diazepam), such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants. Employ usual precautions in the severely depressed or in those with latent depression; suicidal tendencies may be present and protective measures necessary. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation (initially 2 to 2½ mg once or twice daily, increasing gradually as needed or tolerated).

Adverse Reactions: Side effects most commonly reported: drowsiness, fatigue and ataxia. Infrequently encountered: confusion, constipation, depression, diplopia, dysarthria, headache, hypotension, incontinence, jaundice, changes in libido, nausea, changes in salivation, skin rash, slurred speech, tremor, urinary retention, vertigo and blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances and stimulation have been reported; should these occur, use of the drug should be discontinued. Because of isolated reports of neutropenia and jaundice, periodic blood counts and liver function tests are advisable during long-term therapy. Minor changes in EEG patterns (low-voltage fast activity) observed during and after therapy and are of no known significance.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

Supplied: Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg; bottles of 50, 100 and 500.

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useful for the relief of psychic tension, alone or with associated depressive symptoms



Editorial COMMENT

Welcome Members! Speak Your Pieces!

The Board of Trustees, at its June meeting, approved a plan submitted by President E. L. McCafferty, Jr., to hold at least one meeting of the Board in each Vice-Presidential District during the coming year. The purpose of the proposal was to make an all-out effort to bring the Association and its affairs into closer proximity with individual members.

Vice-President J. E. Cameron of the Northeastern Division generously offered his district as a guinea pig for this new program. At this writing the first district meeting has been scheduled to be held in Gadsden on Sunday, August 11, 1968, with the Etowah County Medical Society as host. Every physician in the following counties will be invited to attend this one-day meeting: Madison, Jackson, Marshall, DeKalb, Blount, Cherokee, St. Clair, Calhoun, Cleburne, Shelby, Tallapoosa, Clay, Randolph, Coosa, Talladega and Chambers.

Under the revision of our By-laws, the Board of Trustees sits in the capacity of a reference committee to hear, discuss and make recommendations on all matters concerning the Association and the County societies. As a reference committee its floor is open for discussions both pro and con, by all members of the Association present. This is a democratic process by which the views of the members can be known and duly considered. Presumably, after the debate has been completed, the Board of Trustees will make its decisions for presentation to the Board of Censors, which has final jurisdiction in the interim between Annual Sessions of the Association.

During debate on the proposal for regional meetings of the Board of Trustees some oldtimers recalled that this system had been employed in years past, but was abandoned when interest in the meetings waned to the point of disappearance. However, it was the consensus of most of those present that it is a worthwhile program and that the Board may discover a renewed interest in Association affairs and other problems pertaining to the practice of medicine.

The Board of Trustees has been in existence since the Ordinances of the Association were revised in 1965. It is widely representative of the membership of this Association and its members have established a record for diligent service and faithful attendance at meetings. It can be counted upon to meet at least ten times during any fiscal year, all of these meetings have been held previously at the Association Building in Montgomery with the exception of one meeting held annually at the site of the Annual Session.

Through the medium of the ALABAMA MD, the JOURNAL of the Medical Association of the State of Alabama and the Handbook for Counsellors and Delegates, members have been notified that the Board of Trustees, meeting on the day immediately preceding the opening program of the Annual Session, invites all members to attend and

be heard on any issue of their choice. Some have come, but only a few.

Now the Board is seeking out the members in an effort to make it most convenient for them to lend their voices to those opinions now being expressed which deal with the medical profession and its problems. Perhaps no more interest in regional meetings will be shown this time than in the past. But at least the Board of Trustees will have fulfilled its responsibility to bring organized medicine within easy reach of those who stand to lose or gain so much by its decisions.

The Time For Action Has Arrived

Let's get the show on the road!

This seems to be the attitude of Dr. Thomas H. Alphin, newly designated Director of Health Services for the State Department of Public Health, and Dr. J. Garber Galbraith, Chairman of the Title XIX Advisory Committee. Their initial actions indicate that no time will be lost in developing a Title XIX (Medicaid) program for the under-65 indigent of Alabama well in advance of the January 1, 1970 deadline.

Dr. Galbraith, who rendered yeoman service to this Association as Chairman of the Committee on Aging and The Indigent before it was superseded by the Committee on Socio-Economics of Health Care, has already held one meeting of his Advisory Board, composed of representatives of providers and consumers of service.

This should adequately answer complaints from some quarters that the doctors have been dragging their feet on Title XIX and won designation as the single state agency to administer the program only for the purpose of blocking it.

One year has passed since the late Governor Lurleen B. Wallace redesignated the State Board of Health as the agency to direct a Title XIX program in Alabama. In relieving the Department of Pensions and Security of this responsibility, she placed a tremendous burden upon the physicians of Alabama and the Department of Public Health to produce in a very short time the complicated mechanism necessary to effectuate a Title XIX program.

The first task, and one which has taken a full 12 months to accomplish, was to find a medical director and create an advisory committee to develop a program which would be (1) acceptable to the Department of Health, Education and Welfare; (2) acceptable to all providers and the instruments of government; and (3) economically possible. It hasn't been easy. The Board of Censors has spent fully a hundred hours during the past two years in private and public deliberation on this one problem. Several meetings, formal and informal, have been held with the other providers of services—the Alabama Hospital Association, Alabama Nursing Homes Association, Alabama Pharmaceutical Association, Alabama Optometric Association, Alabama State Nurses Association and other interested parties.

The next hurdle is to devise a Title XIX program which will prove beneficial, workable, and financially possible. No one considers this an easy task. But the physicians of Alabama are fortunate in having two capable and dedicated men such as Dr. Alphin and Dr. Galbraith working in harness on this matter. The Journal confidently believes that if the problems are solvable they will find the answers.

By 1975, some 25 million Americans under 65 are expected to have some or all of their medical care financed by combined federal-state contributions from Title XIX. The program will cover almost twice as many persons as the more familiar Title XVIII Medicare program for the aged.

Title XIX combines the various categories of public assistance—aid to the blind, aid to the permanently and totally disabled, aid to

(Continued on Page 18)

The muscle relaxant that works before you write a prescription

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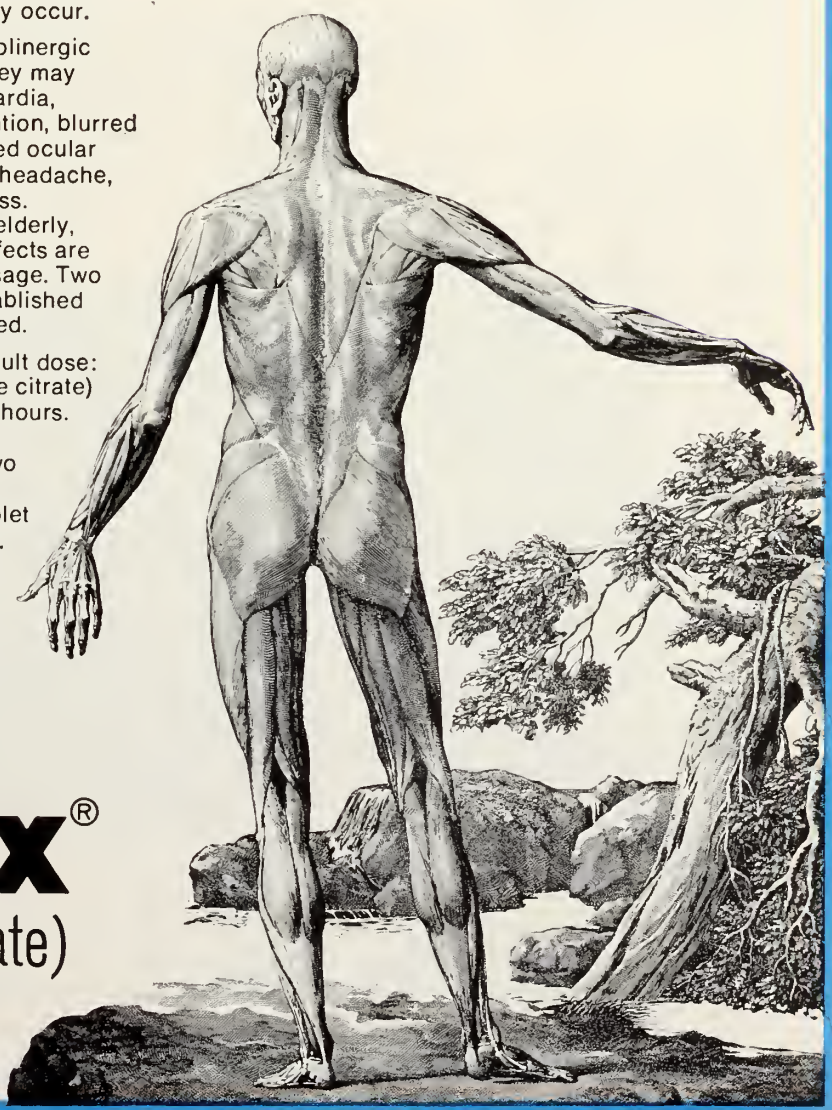
WARNING: Transient lightheadedness or dizziness following NORFLEX-INJECTABLE may occur.

SIDE EFFECTS: Due mainly to anticholinergic action and usually at high dosage. They may include dryness of the mouth, tachycardia, palpitation, urinary hesitancy or retention, blurred vision, dilatation of the pupil, increased ocular tension, weakness, nausea, vomiting, headache, dizziness, constipation, and drowsiness. Infrequently, mental confusion in the elderly, urticaria or other dermatoses. Side effects are usually eliminated by reduction in dosage. Two cases of aplastic anemia, with no established causal relationship, have been reported.

DOSAGE: **INJECTABLE** — Average adult dose: one ampul, 2 cc. (60 mg. orphenadrine citrate) I.M. or I.V. May be repeated every 12 hours. Relief may be maintained with one NORFLEX tablet b.i.d. **TABLETS** — Two tablets per day for adults, one in the morning, one in the evening. Each tablet contains 100 mg. orphenadrine citrate.

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THE TIME FOR ACTION

(Continued from Page 16)

needy families with children, old age assistance to the aged—into one program. The consolidation of the medical aspects of these programs is required by January 1, 1970, or federal aid now being received will be withheld. By 1975 the states must cover the categorically needy and the medically needy.

The categorically needy are those who would qualify for coverage under the various welfare programs, except for minor technicalities. Medically needy are those who have enough money to meet their ordinary living expenses, but whose incomes do not permit them to take care of their health expenses when they become sick.

This pattern is one of establishing financial ability for the poor to get medical care from the same sources and at the same fees as does the population at large.

If the intent of Title XIX is accomplished by 1975, the whole population, in theory, will be self-sufficient with respect to the financing of health services through its own resources, through privately-financed health coverage, or through one of several publicly financed programs of which Title XIX will be by far the largest.

GUEST EDITORIAL

Why Hospitalization Costs Are High

It cost community hospitals an average of $58.06 to provide a patient with a day of care in 1967. This was 15.4 per cent higher than in 1966 when the average cost was $50.31. Wages and salaries account for $36.30 of the present per day expense as compared with $30.92 in 1966. Hospitals on the average now employ 264 persons for each 100 patients. Twenty years ago the ratio was 148/100.

At one time the operating room was the technical center of the hospital. Today there are other technical enclaves beside the operating room—the clinical laboratory, the blood bank, the recovery room, the intensive care unit, and most recently the cardiac care unit. All of these refinements are essential to any hospital that serves as a true medical center for its community. They require specialized staff and equipment unavailable even ten years ago.

One recently installed intensive coronary care unit, consisting of eight beds, requires twenty-four-hour coverage by cardiologists, a specially trained group of 18 nurses, and the most sophisticated electronics equipment now available for constant monitoring of the patient to provide instant diagnosis and treatment of all complications that may arise.

In addition to heart rate, pulse and pacer monitors, and an oscilloscope, all ceiling-hung, each bedside has an electrocardiograph machine and defibrillator and pacemaker equipment. Portable monitoring units at each bedside, connected to the central station, show systolic, diastolic and venous pressure, and temperature.

Central nurses' station equipment can continually monitor any 2 patients' physiologic pressures and temperatures at one time. A console at the station displays all patients' electrocardiograms on individual monitoring oscilloscopes and pulse rate meters. The central station will monitor on a continuous basis each patient's electrocardiogram and constantly stores this information for the current forty-second period on a magnetic tape cartridge.

Should signals of distress from a patient be displayed on the monitoring equipment, an alarm button will sound at the nurses' station in addition to a light signal of distress, sending a medical-nursing team to a stricken

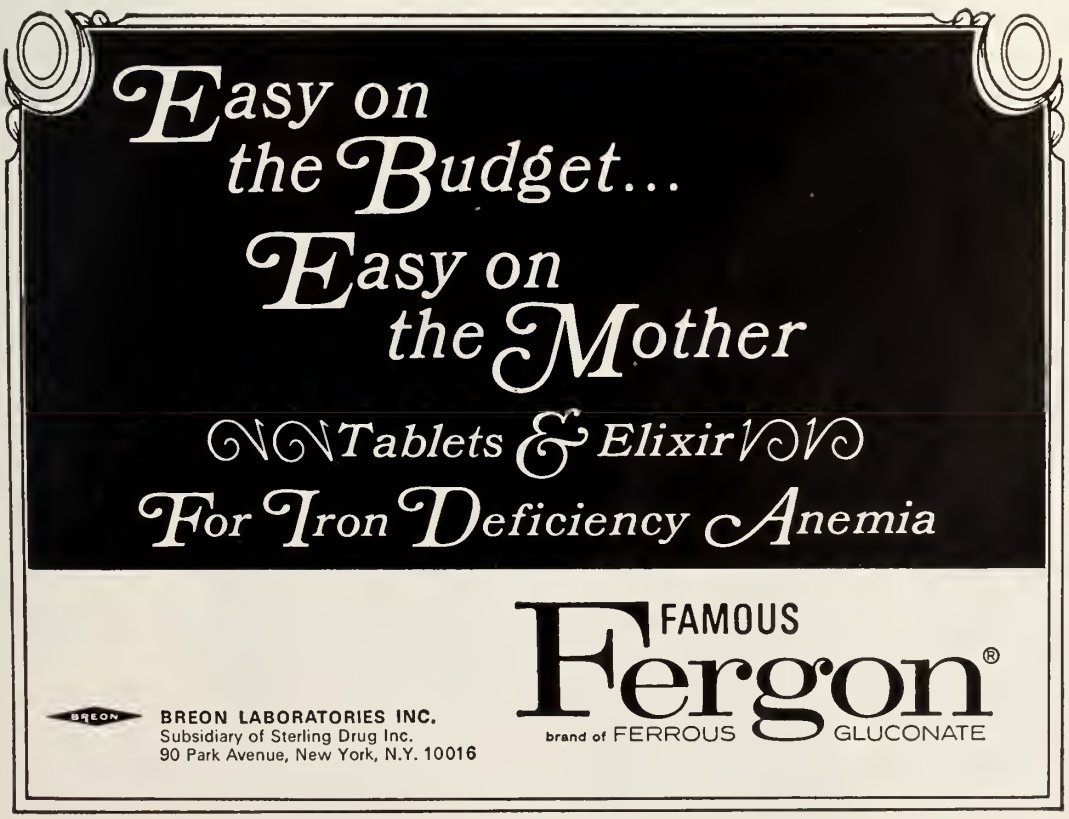
patient's aid in seconds. If more than "all hands on deck" are needed, the nurses' station has a "panic button"— to summon help from an adjacent patient care unit in the hospital. In the event of an alarm condition, the ECG information about a patient stored on the forty-second tape cartridge will be printed on the central station electrocardiograph machine.

In addition, patients' physiologic information from each bedside can be switched to a display, recording, and data storage system in the adjacent treatment laboratory. The information may be recorded on an eight-channel optical recorder, presented on an eight-channel oscilloscope, and/or recorded on a seven-channel, three-speed analog magnetic tape recorder. The tape recorder can play back at the recorded speed or an increased or decreased speed for screening; selected sections then can be printed. The tape recorder also can be programmed to record automatically patient information every fifteen, thirty, or sixty minutes for one-minute periods.

This dream of science fiction is no longer fiction. It is actually at work saving lives in our hospitals.

Similar technologic advances are in actual use in all departments. They are bound to raise the cost of hospitalization, but they lower the mortality rate.

Reprinted from the *New York State Journal of Medicine,* June, 1968.



around the state

New Physicians Licensed To Practice In Alabama



Fay Edward Millett, Jr., M. D., University of Washington School of Medicine, 1962—Intends to locate in Birmingham.

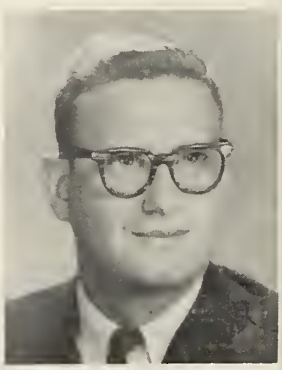


Leo Ray Ingle, Jr., M. D., Indiana University School of Medicine, 1967; interned for a period of one year at Mobile General Hospital, Mobile, Alabama; has served in the U. S. Army for a period of two years.

John David Nofzinger, M. D., Ohio State University College of Medicine, 1958—Intends to locate in Florence.



Richard Lance Sweet, M. D., University of Michigan Medical School, 1966, Reciprocity with Michigan—Intends to locate in Montgomery.





Shirley Fay Sanders Letchman, M. D., Medical College of Alabama, 1963, Reciprocity with National Board of Medical Examiners—Intends to locate in Birmingham.



Cary Jake Lambert, M. D., Medical College of Virginia, 1955, Reciprocity with Virginia. Intends to locate in Atmore-Mobile.

Emerson Jay Mounger, M. D., University of Tennessee College of Medicine, 1963, Reciprocity with Tennessee—Intends to locate in Birmingham.



Clyde Wayne Alexander, Jr., M. D., University of Mississippi School of Medicine, 1964—Intends to locate in Birmingham.

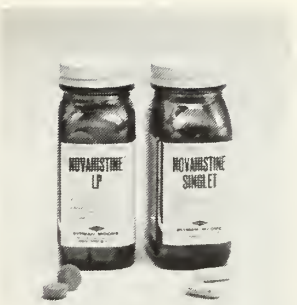
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(Continued on Page 22)

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And let you control the dosage.



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Novahistine LP tablets are most useful for relief of nasal congestion in patients without pain or fever. Novahistine Singlet tablets, which provide analgesic-antipyretic effect, as well as decongestant action, are indicated for upper respiratory infections accompanied by pain, aches and fever.

Whether you prescribe Novahistine LP or Novahistine Singlet, a total daily dose of 3 or 4 tablets will usually provide effective, continuous relief.

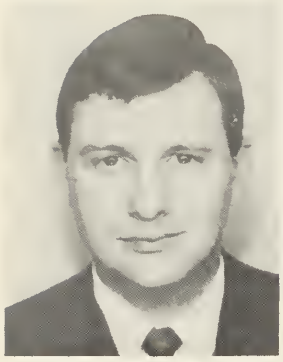
Use cautiously in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

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"Nothing else I've tried seems to work, so I decided to give you a crack at it."

(Continued from Page 20)



William Fletcher Drewry, Jr., M. D., Medical College of Alabama, 1966; interned for a period of one year at University of Alabama Hospitals, Birmingham, Alabama; is presently serving a residency at University Hospital and Hillman Clinics, which will probably be interrupted by military service obligation through the Berry Plan.



Donald McMahon, Jr., M. D., Tulane University School of Medicine, 1952—Intends to practice in areas of Alabama (consultation) and reside in Pensacola, Florida.



Darryl Lee Dochterman, M. D., University of Iowa College of Medicine, 1966—Intends to locate in Montgomery (Maxwell AFB).



Chester Milton Berlin, Jr., M. D., Harvard University, 1962, Reciprocity with National Board of Medical Examiners—Intends to locate in Birmingham.



Barney Edwin Elliott, Jr., M. D., University of Louisville School of Medicine, 1962—Intends to locate in Huntsville.



Robert Alexander Wynn, M. D., Medical College of Georgia, 1965, Reciprocity with Georgia—Intends to locate at Fort McClellan, Ala.



George Washington Galloway, Jr., M. D., University of Tennessee College of Medicine, 1958—Intends to locate in Hartselle.



Robert Campbell Alig, M. D., Tulane University School of Medicine, 1964, Reciprocity with Louisiana—Intends to locate in Anniston.



David Barnett Graves, M. D., Medical College of Alabama, 1966—Intends to locate in Birmingham.



Johnny Cleveland Elliott, M. D., Medical College of Alabama, 1964, Reciprocity with National Board of Medical Examiners—Intends to locate in Henagar.

Robert Baker Hale, Jr., M. D., Vanderbilt University School of Medicine, 1963, Reciprocity with Tennessee—Intends to locate in Huntsville.



Jean Garrick, M. D., Georgetown University School of Medicine, 1965, Reciprocity with Maryland—Intends to locate in Montgomery.



County Society Meetings

Coffee County

Dr. Rube R. Hundley of Dothan spoke on "Difficult Urological Diagnoses" at the business and scientific meeting of the Coffee County Medical Society on May 2. Other business included the organization for participation in Setwire T. B. Program.

Thirteen members were present at the Gibson Hospital. Dr. T. Riley Lumpkin, president, presided. Next meeting will be on July 18.

Cullman County

Congressman Tom Bevill of the 7th District spoke on Medical Legislation at the meeting of the Cullman County Medical Society.

Drs. H. A. Pinkerton and H. C. Ensor were elected to membership in the society.

The next meeting will be held on October 7.

Escambia County

Dr. William J. Tally of Gadsden was the principal speaker at the May meeting of the Escambia County Medical Society. Fifteen members were present, Dr. C. S. Crawford presided. Dr. Tally spoke on "Tuberculosis."

The next meeting will be held on September 4.

Etowah County

Dr. J. Clayton Davie, Assistant Professor of Neurosurgery at the Medical College of Alabama spoke on "Stereotatic Neurosurgical Procedures," at the May meeting of the Etowah County Medical Society. Dr. Orville Morgan, president, presided and 28 members were present.

Dr. William Tally will be the speaker at the next meeting.

Geneva County

Dr. Frederick S. Wolf, Director, Tuberculosis Control Program, State Department of Public Health, was speaker at the May meeting of the Geneva County Medical Society. His subject was "Tuberculosis and Our Community."

Dr. Hoyt A. Childs, Vice-President, presided at the meeting. Seven members were present.

Lee County

Dr. John Durwood Bradley, Jr., was principal speaker at the June meeting of the Lee County Medical Society. His subject was "Respiratory Failure."

Seventeen members were present. Dr. Byron Knapp, president, presided.

The next meeting will be held in September.

Montgomery County

Principal speaker at the June meeting of the Medical Society of Montgomery County was Col. Leroy R. Priest. He spoke on "Rehabilitation." The meeting was held at the

Central Alabama Rehabilitation Center with 70 members present. Dr. Ross McBryde, president, presided.

The next meeting will be held in October at the Whitley Hotel.

Morgan County

Dr. Herbert Street, an ophthalmologist in private practice in Decatur, spoke at the June meeting of the Morgan County Medical Society. Dr. J. Paul Peters, president, presided. Thirty-eight members were present.

A quarterly business meeting will be held in July.

Vital Statistics

NEW MEMBERS

Covington County

Spurlin, Richard J., Opp, Ala. 36467.

Jefferson County

Cranton, John Richard, 1919 7th Ave., South, Birmingham, Ala. 35233.

Dodson, William Herbert, 1919 7th Avenue South, Birmingham, Ala. 35233.

Estock, Robert, 1700-7th Avenue South, Birmingham, Ala. 35233.

Goldfarb, Morton, Carraway Methodist Hospital, Birmingham, Ala. 35234.

McAuley, Malcolm Deaton, Jr., Carraway Methodist Hospital, Birmingham, Ala. 35234.

Wells, Benjamin Baxter, 1919 7th Avenue South, Birmingham, Ala. 35233.

Montgomery County

Wolf, Frederick Samuel, State Department of Public Health, Montgomery, Ala. 36104.

Morgan County

Johnson, Jimmy Robert, 1107 16th Ave., S. E., Decatur, Ala. 35601.

Tuscaloosa County

Barrett, Joseph Eagle, Partlow State School, Tuscaloosa, Ala. 35401.

Standeffer, William Carter, 400-B 10th Street E., Tuscaloosa, Ala. 35401.

Taylor, William Arnold, 922-5th Avenue E., Tuscaloosa, Ala. 35401.

MEMBERS DECEASED

Etowah County

Agricola, Frederick Theodore, Jr., 1011 Forrest Avenue, Gadsden, Ala. 35901—deceased April 20, 1968.

Houston County

Spann, Charles Lewis, Plaza Medical Center, 211 West Main St., Dothan, Ala. 36301—deceased May 15, 1968.

Jefferson County

Garrison, John Earl, 1132 South 10th Place, Birmingham, Ala. 35205—deceased May 13, 1968.

Montgomery County

McConnico, Frank Hawthorne, 5 South Capital Parkway, Montgomery, Ala. 36107—deceased May 2, 1968.

NON-MEMBERS DECEASED

Montgomery County

Corson, Wesley Connelley, 2385 Wildwood Drive, Montgomery, Ala. 36111—deceased April 24, 1968.

MEMBERS MOVED

Covington County

Little, Rufus LeRoy, Jr., Pathology Department, VA Hospital, Little Rock, Ark.—moved from state.

Jefferson County

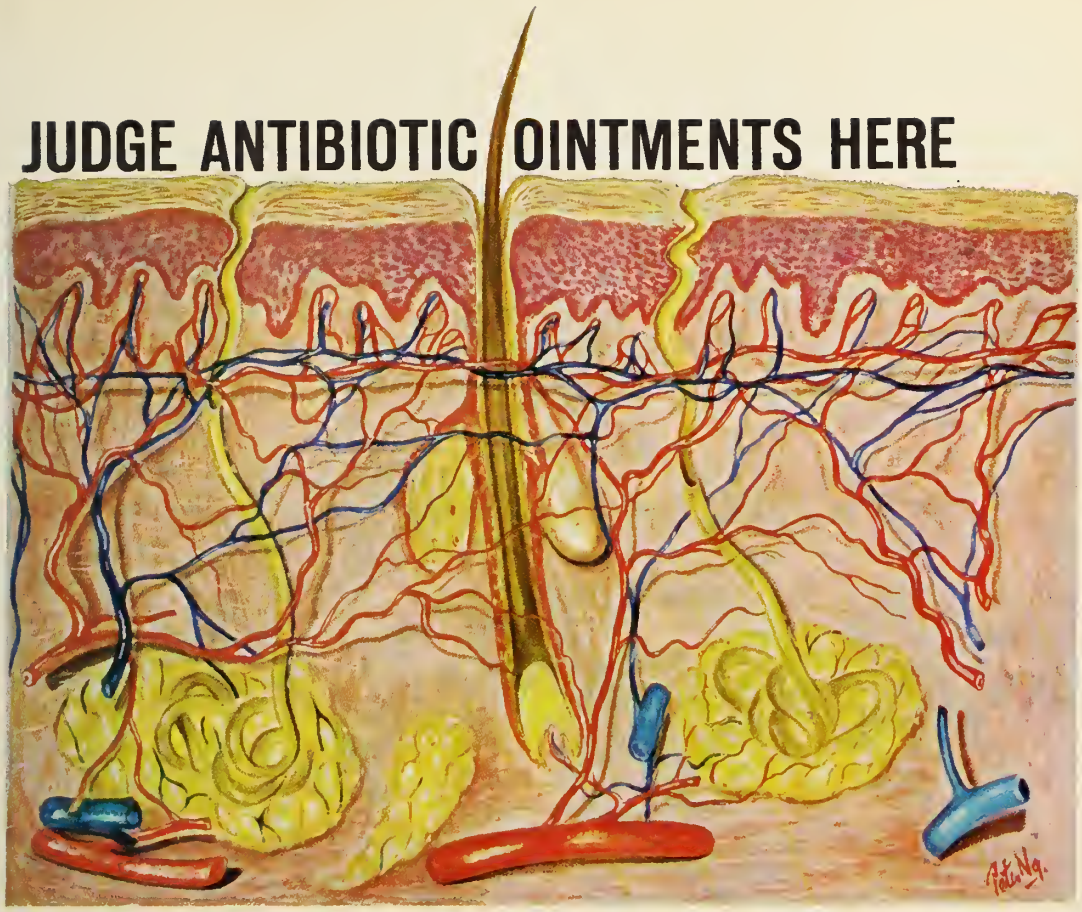
Argires, James Peter, University Hospital, Birmingham, Ala. 35233—moved from county.

Minear, Ralph Edward, Jr., 203 Park Drive, Apt. No. 43, Boston, Mass.—moved from state.

Pirce, James Howard, 1919 7th Avenue South, Birmingham, Ala. 35233—moved.

(Continued on Page 31)

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Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

Supplied: Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip.

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Therapeutic breakthrough in non-narcotic control of the pain of trigeminal neuralgia

Tegretol®
carbamazepine

Warning
Fatal cases of aplastic anemia have been reported following treatment with Tegretol. Agranulocytosis, thrombocytopenia and transitory leukopenia have also been observed.
Complete blood and platelet counts should be done prior to and at regular intervals during treatment with the drug (see recommendations under "Important Note and Precautions") to help in the early detection of serious bone marrow injury. Abnormalities in initial blood tests should rule out use of the drug. Also, patients should be made aware of such early toxic signs of a potential hematologic problem as fever, sore throat, mouth ulcers, easy bruising and petechial or purpuric hemorrhage. Should such signs appear, the patient should be advised to discontinue the drug and to report to the physician immediately.

Indication Tegretol is indicated in the treatment of the pain associated with true trigeminal neuralgia. It is not a simple analgesic and should never be administered for relief of trivial facial aches or pains.
Contraindication Do not use in those with a known sensitivity to any tricyclic compound or in those being treated with M.A.O.I. agents. As long a period as possible should elapse before using Tegretol in patients who have been treated with M.A.O.I.'s, with a minimum of 7 days. In such cases, initial dosage should be low and the patient's reaction to gradual increments closely observed.
Important Note and Precautions Familiarity with the clinical symptoms which lead to an accurate diagnosis of true trigeminal neuralgia and with the complete prescribing information, careful patient selection, a thorough examination before treatment and close patient supervision throughout the treatment period are essential to the safe and effective use of this drug.
Where feasible, Tegretol should not be used in conjunction with any potent drug which may increase the possibility of toxic reactions.
In pregnancy, the drug should not be prescribed during the first trimester and thereafter only to patients in whom the clinical situation warrants the potential risk. It should not be administered to nursing mothers.
Patients with increased intraocular pressure should be closely observed during treatment with this drug because of its anticholinergic effect.
Because of the drug's relationship to other tricyclic compounds, the possibility of activation of latent psychosis and, in the elderly, of confusion or agitation, should be considered.
Dizziness and drowsiness may occur and patients should be cautioned about the hazards of operating machinery or automobiles and of engaging in other hazardous tasks.
Use cautiously in patients with a history of coronary artery disease, organic heart disease, congestive failure or liver disease.
Before initiating therapy, the following laboratory procedures should be performed:
1. Complete blood and platelet counts which, if abnormal, should rule out the use of the drug.
2. Baseline evaluations of liver function.
During treatment with Tegretol, the following laboratory procedures should be performed:
1. Complete blood and platelet counts should be done at intervals of one week during the first month of drug treatment, every two weeks during the second and third months, and at monthly intervals thereafter for as long as the patient is taking the drug. A trend toward a decreasing white blood cell count should suggest a dosage reduction and more frequent laboratory and clinical evaluations. Should this trend continue, the dru should be discontinued.
2. Liver function tests must be performed at regular intervals during tre ment with this drug since liver damage may occur during therapy. The drug should be discontinued immediately in cases of aggravated liver dysfunction or active liver disease.
3. Periodic eye examinations, including slit-lamp, funduscopy and tonom etry, are recommended for patients being treated with this drug since many phenothiazines and related drugs have been shown to cause eye changes.
4. Complete urinalysis and BUN should be done on patients treated w Tegretol because of observed renal dysfunction.
Adverse Reactions Dizziness, drowsiness, unsteadiness on the feet, nausea, vomiting, aplastic anemia, transitory leukopenia, agranulocytos eosinophilia, leukocytosis, thrombocytopenia, purpura, abnormalities in liver function tests, cholestatic and hepatocellular jaundice, urinary fre quency, acute urinary retention, oliguria with elevated blood pressure, albuminuria, glycosuria, elevated BUN, microscopic deposits in the uri impotence, disturbances of coordination, confusion, headache, fatigue blurred vision, transient diplopia and oculomotor disturbances, speech disturbances, abnormal involuntary movements, peripheral neuritis and paresthesias, depression with agitation, talkativeness, nystagmus, tinnitus, paralysis and other symptoms of cerebral arterial insufficiency, pruritic and erythematous rashes, urticaria, Stevens-Johnson syndrom photosensitivity reactions, alterations in skin pigmentation, exfoliative dermatitis, alopecia, diaphoresis, recurrence of thrombophlebitis, eryth multiforme and nodosum, aggravation of disseminated lupus erythema-tosus, gastric distress, abdominal pain, diarrhea, constipation, anorexi dryness of the mouth and pharynx, glossitis, stomatitis, fever, chills, adenopathy, lymphadenopathy, aching joints and muscles, leg cramps, conjunctivitis, left ventricular failure, aggravation of hypertension, hypo tension, syncope and collapse, edema, aggravation of coronary artery disease and congestive heart failure. (Whether these cardiovascular eff are drug-related is not known. However, some of these complications h resulted in fatalities.) The necessity for discontinuing the drug should b dictated by the gravity and severity of the adverse reactions.
Dosage and Administration The drug should always be taken with mea if possible.
Initial: One-half tablet (100 mg.) b.i.d. on the first day. Thereafter, the d should be increased in one-half tablet (100 mg.) increments every 12 h until freedom from pain is achieved. To relieve pain, between 200 mg. a 1200 mg. per 24 hours may be necessary.
Maintenance: Initial control of pain can be maintained in most patients with a dose of 400 mg. to 800 mg. daily. Maintenance doses may range between 200 mg. and 1200 mg. daily.
At least once every 3 months during treatment period attempts should b made to discontinue the drug or to reduce the dose to the minimum effective level.
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Warning: With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has frequently been required and deaths have occurred. Discontinue enteric-coated potassium supplements immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur.

Use with caution in pregnant patients. Since the drug may cross the placental barrier, adverse reactions which may occur in the adult (thrombocytopenia, hyperbilirubinemia, altered carbohydrate metabolism, etc.) are potential problems in the newborn.

Precautions: Antihypertensive therapy with this drug should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents or other potent antihypertensive drugs, or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. Barbiturates, narcotics or alcohol may potentiate hypotension. Because of the possibility of progression of renal damage, periodic determination of the BUN is indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated.

Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, the drug should be discontinued and potassium supplements given, provided the patient does not have marked oliguria.

Take special care in cirrhosis or severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended.

Adverse Reactions: Nausea, gastric irritation, vomiting, anorexia, constipation and cramping, dizziness, weakness, restlessness, hyperglycemia, hyperuricemia, headache, muscle cramps, orthostatic hypotension, aplastic anemia, leukopenia, thrombocytopenia, agranulocytosis, impotence, dysuria, transient myopic skin rashes, urticaria, purpura, necrotizing angiitis, acute gout, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Other reactions reported with this class of compounds include: jaundice, xanthopsia, paresthesia, and photosensitization.

Average Dosage: 50 or 100 mg. with breakfast daily or 100 mg. every other day.

Availability: White, single-scored tablets of 100 mg. and aqua tablets of 50 mg., in bottles of 100 and 1000

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Sarrell, Warren G., present Anniston, Ala. 36201, to P. O. Box 2127, Anniston, Ala. 36201.

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Cress, Robert H., present Birmingham, Ala. 35233, to Department P. M. & R., Albany Medical Center, Albany, New York 12208.

Cunningham, William A., present Birmingham, Ala. 35233, to 3333 N. E. 34th Street, Apt. 1105, Ft. Lauderdale, Fla. 33308.

Gillis, Samuel P., present Birmingham, Ala. 35233, to 1815 11th Avenue South, Suite 4, Birmingham, Ala. 35233.

Hogan, Marshall D., present Morristown, New Jersey 07960, to 80 Overlook Road, Morristown, New Jersey 07960.

Ippolito, Jerome G., present Birmingham, Ala. 35205, to 800 Clinic Lane, Bessemer, Ala. 35020.

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(Continued on Page 34)

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Picture Highlights of AAGP Meeting









Top: New AAGP officers left to right: President-Elect, Dr. George E. Rudd of Pinson; Director at Large, Dr. John S. Pilkington of Selma; and new president, Dr. T. Riley Lumpkin of Enterprise.

Center-left: Dr. T. Riley Lumpkin presents the Past President's Plaque to Dr. Grover Murchison.

Center-right: General Chairman, Dr. Jerre White, Tuscaloosa, welcomes AAGP members.

Left: Dr. M. C. Holcomb, Birmingham; and Dr. Stanley Hand, Athens; were elected delegates to the American Academy of General Practice.

Dr. Horton Honored By Clinical Investigators

Birmingham, Alabama. . .Dr. Richard Horton, a faculty member at the Medical College of Alabama, was one of 50 scientists in the United States elected to membership in the American Society for Clinical Investigation during the Society's annual meeting, May 5-6, in Atlantic City.

Membership in this national society is limited to a maximum of 55 individuals annually, although only 50 were named this year. The A. S. C. I. membership roster includes some of the nation's most outstanding scientists involved in medical research.

Dr. Horton joined the Medical College of Alabama faculty in September 1967 as associate professor of medicine and assistant professor of physiology and biophysics. His research interest lies in the field of steroid hormones in normal and abnormal states in human beings. He has had extensive training in both basic science and clinical medicine.

He attended Syracuse University, Syracuse, New York, from 1950-52, and subsequently earned his baccalaureate degree in 1954 and his M. D. degree (cum laude and with thesis honors) in 1958, both from the University of Washington in Seattle.

Following an internship at a Seattle hospital, Dr. Horton completed a residency at the Veterans Administration Hospital—U. C. L. A. Medical Center. The following four years he was a Public Health Service Fellow in Endocrinology—first at the University of California Medical Center's Metabolic Unit, San Francisco, then at the Worcester Foundation for Experimental Biology, Shrewsbury, Massachusetts.

Prior to joining the Medical College of Alabama faculty, Dr. Horton was assistant professor of medicine and a N. I. H. Career Development Awardee at the U. C. L. A. School of Medicine.

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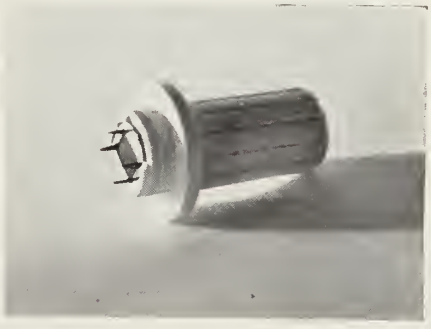
A special communication, which was presented verbally before the Conference-Workshop on Regional Medical Programs last January by Dwight L. Wilbur, M. D., President-Elect of the American Medical Association, has been produced in reprint form. The four-page article, "Quality and Availability of Health Care Under Regional Medical Programs," was published originally in the March 11 issue of JAMA.

In Dr. Wilbur's opinion, the act (Regional Medical Programs authorized under Public Law 89-239) is quite extraordinary in many respects. "The diverse interpretations among various observers of its long-term objectives suggest many misunderstandings and an uncertain but hopefully great future," Dr. Wilbur points out.

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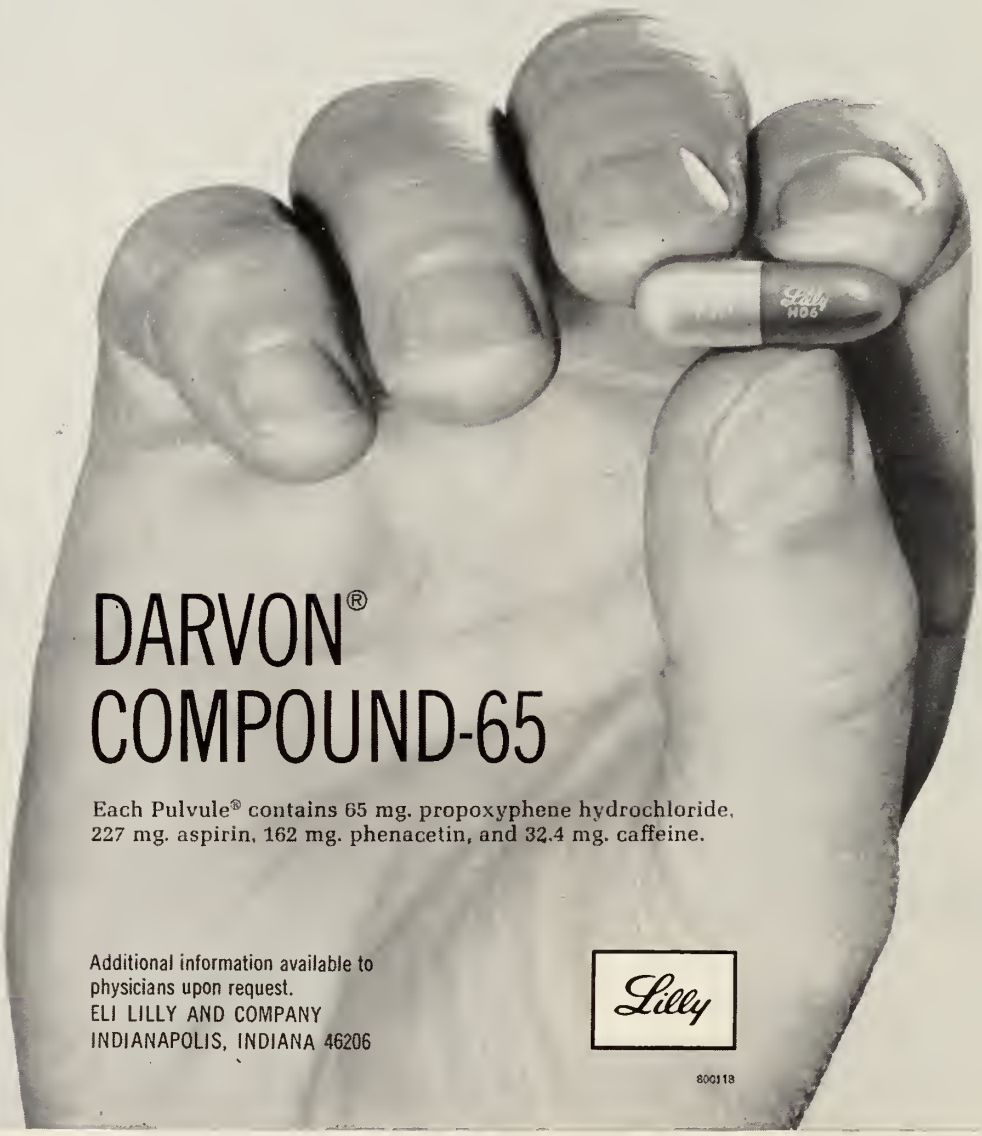
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Surgical Treatment for Heart Block

By

Charles J. Donald, Jr., M. D., Orville W. Clayton, M. D.,

and

Thomas A. S. Wilson, M. D.

Birmingham, Alabama

The implanted cardiac pacemaker is now the standard method of treatment for the relief of heart block. We now have dependable pacemakers that can function for two to three years without failure. Improved surgical technique has also led to a simplified operative approach which will improve the long term results of cardiac pacing. Patients without surgery have 40 per cent[1] one year mortality. Patients treated with implanted pacemakers have a 10 per cent one year mortality.

The first pacemakers required a thoracotomy with implantation of electrodes by suturing them into the epicardial surface of the left ventricle. The results of this method, however, led to re-operation in 42 per cent of the cases within the first year.

Chardack[2] et al in 1965 introduced a simplified method of pacemaker implantation, namely the permanent transvenous catheter electrode pacemaker. This method does not require a thoracotomy. The electrode is introduced by either the external jugular vein, internal jugular vein or the cephalic vein and passed down the superior vena cava into the right atrium and right ventricle under fluoroscopic control. The blunt tip of the electrode is imbedded into the trabeculae at the apex of the right ventricle. Imbedding the tip minimizes movement and displacement of the electrode. The generator is then implanted in a subcutaneous pocket in the anterior chest wall. It is imperative that the electrode be firmly secured to the jugular or cephalic vein to prevent displacement.

General anesthesia has been used in most cases. I. V. Isuprel and Xylocaine are always available. We use continuous E. C. G. monitoring during the surgery and for at least 24 hours following implantation of the pacemaker. A defibrillator and external pacemaker is always available. One patient has

required the use of the defibrillator and one the external pacemaker.

At present, we are using two types of pacemakers. In complete heart block, we use a fixed rate pacemaker which is usually set at 72 to 78 beats per minute. For intermittent heart block, we use a demand pacemaker which only functions when heart block occurs. The demand pacemaker initiates a stimulus only after a preset interval following a Q R S complex thus imitating the escape mechanism of the heart. The demand pacemaker initiates no impulse if the spontaneous heart rate exceeds the preset generator rate. This prevents the pacemaker from competing with a normal rate. In one case, a pulse generator with twice the usual milliamp output was necessary because of an increased threshold stimulus of the electrode. In all cases we have used a pulse generator made by Medtronic[3] which carries a three-year warranty. The generator has a variable output from one to five volts. The bipolar electrode is insulated with heat-cured, medical grade Silicone rubber.

We formerly used a temporary transvenous pacemaker before proceeding with the permanent type. At the present time, however, we will use a temporary transvenous pacemaker only if a permanent pacemaker is not available or when heart block is associated with an acute myocardial infarction. The temporary pacemaker has been used on 13 out of 43 cases. In spite of the fact that the majority of our cases were past 70, we have had no operative or hospital deaths.

Age	Pacemaker
40-50	1
50-60	1
60-70	11
70-80	21
80-90	9
	43
Mortality	0

Three have subsequently died—two due to a stroke and the third one due to a coronary occlusion. In the past two years, we have had 43 patients with either complete or intermittent heart block. These patients have had 56 operative procedures with no mortalities.

Heart Block

Cases	43
Operations	56
Mortality	0

Of this group we have put in the demand pacemaker in nine cases.

Complications
Post-Operative Complications

Hiccoughs	3
Perforated Ventricle	1
Poor Position of Electrode	4
Erosion of Skin	1
Battery Failure	4

1. Phrenic nerve irritation causing hiccoughs has occurred in three instances. In two of the cases, a second operative procedure was necessary to pull the electrode back away from the phrenic nerve with complete relief.

2. The third case of hiccoughs was associated with a late perforation of the ventricle by the electrode. This occurred approximately six weeks after the pacemaker and electrode had been inserted. This is the only patient that required a thoracotomy. At surgery, the electrode was found within the pericardial sack adjacent to the phrenic nerve causing diaphragmatic contraction. A small amount of serous fluid was present in the pericardium without any active blood. We then sutured the electrode to the ventricle away from the phrenic nerve with relief of the hiccoughs and the patient subsequently recovered.

3. Erosion of the electrode through the skin in the neck occurred in one patient ap-

proximately two and one-half months following the implantation. Under local anesthesia, this was again buried beneath the skin without any further difficulty.

4. The fifth complication is hematoma in the wound. This occurred in two cases.

5. Pacemaker failure with tachycardia has occurred in two cases.

6. Improper positioning of the electrode in the coronary sinus has led to re-operation in two instances.

7. Infection—We have had no infections.

8. Increased electrode threshold stimulus.

Re-Operations

Re-operation was necessary for a variety of reasons.

1.	Mr. L. H. L.	Age: 74
	3-8-66	Hiccoughs—Electrode adjustment
	12-30-67	Battery replacement 22 months later
2.	Mrs. M. M.	Age: 76
	9-1-66	Electrode eroded through skin 6 months later
3.	Mr. C.	Age: 63
	11-7-66	Pacemaker
	12-30-67	Electrode adjustment
4.	Dr. D.	Age: 72
	11-9-67	Pacemaker
	12-11-67	Poor position of electrode
5.	Mrs. G. S.	Age: 86
	12-27-67	Pacemaker
	12-30-67	Battery replacement-higher voltage
	1-15-68	Perforation with epicardial suture
6.	Mr. P. M.	Age: 73
	12-27-67	Poor position of electrode in coronary sinus
	12-28-67	Adjustment of electrode
7.	Mrs. F. W.	Age: 62
	5-29-67	Pacemaker
		Hiccoughs — Electrode adjustment
8.	Mrs. M. V.	Age: 67
	12-14-67	Poor response
		Electrode adjustment 10 days later
9.	Mr. J. P. L.	Age: 71
	1-15-68	Pacemaker
	3-21-68	Increased rate

Type Pacemaker

Fixed Rate	36
Demand	9

Conclusion

Heart block can now be safely treated with the use of the transvenous pacemaker.

References

1. Cardiac Pacemakers and Pacing, Sowton, E.; Modern Conception of Cardiovascular Disease, V. 36, No. 6, P. 31.

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3. Furmon, S., Escher, J. W., Soloman, N. and Schwadel, J. B.; Implanted Transvenous Pacemaker: Equipment, Technique and Clinical Experiences; American Surgery 164:465, 1966.

The Treatment of Rheumatoid Arthritis As Seen by a Physiatrist

By

R. H. Cress, M. D.*

and

W. C. Fleming, M. D.**

Abstract

Rheumatoid arthritis is defined, its various characteristics and courses are discussed. Discourse covers methods of diagnosis, medical and physical treatment procedures, prevention of deformities, family instruction, and value of early referral. A basic therapeutic program includes the establishment of a good patient-physician relationship, control of pain with analgesics, rest and activity in balanced amounts, a proper physical therapy program and careful attention to the general health of the patient. Goals of treatment are preservation of normal range of motion of the joints, maintenance of the strength of the muscles supporting the joints, improvement of the performance of those activities of daily living which are necessary for self sufficiency, maintenance of general musculoskeletal facility, relief of pain and inflammation, support of general health and well-being. Special stress is given to a doctor's total approach to and lifelong followup of a rheumatoid arthritic's case.

The Treatment

Rheumatoid arthritis is a chronic disease associated with widespread inflammatory involvement of connective tissue characterized especially by articular manifestations which are generally persistent and progressive, commonly leading to varying degrees of deformity and disability. Onset of the disease occurs most commonly between the age of 20 to 60 years with peak incidences at age 35 and 45. It may begin, however, at any age from the first year of life to the ninth decade. In clinic populations women are affected more frequently than men in a ratio of two or three females to one male.[2] It is more common among the lower income groups. It has been estimated that one out of every ten persons over the age of 14 are afflicted with some form of arthritis or rheumatism, and more than 50 per cent of the instances of crippling involve persons over 45 years of age.[4]

The etiology of rheumatoid arthritis is unknown.[10] Infectious agents, nutritional abnormalities, endocrine abnormalities, sympathetic or autonomic system dysfunction, personality disturbances, hypersensitivity and autoimmune mechanisms have been postulated but have not been established as a specific cause. The only statement one may make about the genetic aspects of rheumatoid arthritis is a tentative conclusion that genetic influences probably play a role in its development.[2, 10]

Pathologically the disease is characterized by inflammation. Initial joint changes suggest an exudative inflammation of the synovium. This changes to a proliferative inflammation which is the outstanding characteris-

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tic of rheumatoid arthritis. The development of granulation tissue which is converted into dense scar tissue dominates the latter phase of the disease.[10] A characteristic of the granulation tissue is its growth and invasion beneath the articular cartilage in a sheet called a pannus. This results eventually in complete destruction of the articular cartilage. Finally only scar tissue extends across the joint from bone to bone producing a fibrous ankylosis which in time becomes bony.

Although joints are the main sites of pathological changes in rheumatoid arthritis, lesions occur in non-articular structures as well. Muscles, nerves, tendons, bursae and even skin are involved. Lesions are found in serous membranes, in the heart, reticuloendothelial structures, intestines and other locations.[2, 10] Muscle atrophy is out of proportion to disuse. Pain, muscle imbalance, and joint destruction results in contractures, subluxations, and complete dislocation and destruction of joints.

Subcutaneous nodules occur in 15 to 20 per cent of arthritis.[2, 10, 7] They occur over the forearm, extensor surfaces and at sites of trauma. They are usually subcutaneous but may be attached to the skin or periosteum. They have been described in tendons, tendon sheaths, pleura, lungs, and other structures.[7]

Clinically rheumatoid arthritis presents with fatigue, joint pain, swelling and stiffness after activity, weight loss, low grade fever and anemia.[2, 1, 10, 7] The proximal interphalangeal joints are characteristically involved in the hands. The joint pain in rheumatoid arthritis is not as severe as that seen in gout, infectious arthritis or rheumatic fever and mild to moderate pressure is required when examining the joint to produce discomfort.

Laboratory findings in rheumatoid arthritis include: an elevated sedimentation rate, a moderate normocytic hypochromic enemia, and a positive latex fixation or other test for rheumatoid factor in 55 to 90 per cent of patients who have had the disease one year or more.[10, 7, 6, 11] If the disease is far enough advanced, radiological changes are evident.[8]

The course of rheumatoid arthritis is variable. Rheumatoid arthritis may run a short course of a few months with complete disappearance of symptoms for months or years. In the majority of patients the disease returns and with each recurrence assumes a more chronic form. Even in patients in whom the disease follows a chronic progressive course, there are often periods of comparative comfort alternating with periods of disease activity. About 15 to 20 per cent of rheumatoid arthritics have severe permanent disability due to continuous activity of their disease.[1] The majority of patients learn to live within the limitations imposed by their illness. Generally the degree of disability parallels the severity and duration of the active disease.

The prognosis for the individual patient with rheumatoid arthritis is uncertain. The presence of the rheumatoid factor is said to indicate a bad prognosis. Onset of rheumatoid arthritis earily in life together with the presence of the rheumatoid factor is said to be indicative of sustained disease and hence more severe disability.[9]

The aim of any program of treatment of rheumatoid arthritis is to control the disease medically or induce a remission with reduction in the activity of the disease.[3] A number of drugs are useful in attempting to achieve this result. Salicylates, gold salts, phenylbutazone, antimalarial compounds, indomethocin, and corticosteriods are currently available. The physician should be aware of the advantages, disadvantages and side effects of each. Treatment should generally be, stepwise, from the simplest to the most complex. A basic therapeutic program should be used initially in each patient with rheumatoid arthritis which will serve as a foundation for additional measures. Most au-

thorities agree that this program includes: (1) establishment of a good patient-physician relationship, (2) control of pain with analgesics, (3) rest and activity in balanced amounts, (4) a proper physical therapy program, (5) careful attention to the general health of the patient.[2, 10, 3] This program should be continued three to six months before additional measures are considered.

Such a program can best be instituted while the patient is hospitalized. This provides an opportunity for establishing patient rapport and good rest habits, as well as providing an opportunity for education in the performance of physical and occupational therapy measures which can be continued after discharge. It cannot be overemphasized that rest is one of the cornerstones of such a program. Eight hours of sleep at night as well as a one hour rest period, morning and afternoon, are mandatory in the average arthritic. Exercise should be carefully gauged to the patient's fatigue and joint tolerance. During such a period of hospitalization the physician must be able to control the disease medically or provide sufficient analgesics for the patient to cooperate in a program of education for home care involving physicians, nurses, physical and occupational therapists.

The goals of the physical and occupational therapist in the treatment of the rheumatoid arthritic are: (1) preservation of normal range of motion of the joints, (2) maintenance of the strength of the muscles supporting the joints, (3) improvement of the performance of those activities of daily living which are necessary for self-sufficiency, (4) maintenance of general musculoskeletal facility, (5) relief of pain and inflammation, (6) support of general health and well-being.[1] The achievement of these goals is predicated upon reasonable medical control of the rheumatoid process and referral of patients with rheumatoid arthritis early in their disease so that a dynamic and progressive physical program may be instituted and continued throughout the remainder of the patient's life.[1, 5]

Preservation of normal range of motion of the joints can be obtained by the use of proper bed positioning, appropriate splints and passive exercises. These principles are applicable to the rheumatoid arthritic with acute red, tender, swollen joints who cannot participate in an active exercise program.

Passive exercises are exercises performed on the patient in which a joint is moved through a range of motion by another individual. It is known that if a joint is carried through a complete range of motion daily, significant loss of motion will be minimized or prevented. Proper bed positioning includes the use of a thin pillow, bed board beneath the mattress, and a properly applied foot board, the avoidance of a pillow beneath the knees and a gradual tolerance of the prone position.

The two contractures said to cause the rheumatoid arthritic the greatest functional disability are limitation of arm abduction and knee flexion deformity. It must be remembered that it is usually impossible to have knee flexion deformities without also having hip flexion deformities. If the rheumatoid arthritic spends one to two hours out of each 24 in the prone position he will do a great deal to prevent or minimize hip flexion contractures which are equally disabling. The rheumatoid arthritic should be taught isometric exercises (tension without motion) specifically aimed at preserving the strength of his hip and knee extensors. These exercises can be utilized in those patients in which motion of the hip and knee joints are not desired. It is essential that a member of the patient's family be instructed in properly applied passive exercises to enable the rheumatoid arthritic to receive these when his disease process prohibits an active exercise program.

Maintenance of the strength of the muscles supporting the joints is best obtained by an active exercise program. Active exercises

are exercises performed by the patient and may involve movement of the body part alone against gravity or movement of the body part plus a weight (resistive exercises). Active exercises alone without resistance maintain range of motion, coordination, and endurance. Resistive exercises increase muscle strength and bulk. Such exercises must be carefully taught and supervised. The patient must be impressed with the importance and necessity of performing one or both types of exercise on a routine daily basis.

Precautions with respect to exercise are in order. If not properly cautioned many patients with rheumatoid arthritis will adopt the philosophy that "I must be active all the time or I will be a cripple in a wheelchair." As we have stated before the cornerstone of the physical treatment of rheumatoid arthritis is rest. Rest and exercise in balanced amounts are essential. More rheumatoid arthritics have done irreparable damage to their joints by continuing to actively use warm, hot, swollen tender joints than have been damaged by bed rest. One must advise the rheumatoid arthritic to gauge his physical activity by his fatigue and joint tolerance. He should cease his activity when he is fatigued. If the rheumatoid arthritic can perform a certain activity without joint pain, tenderness, redness or swelling it is considered safe to perform such activity. If discomfort following performance of an activity is mainly muscular or peri-arthritic and persists one to three hours then caution must be observed. Generally it may be said that it would be safe to perform one half as much activity the next day or when the discomfort has subsided. If discomfort or pain persists four hours or more, or the patient's joint or joints are painful, hot, swollen, red and tender he must cease activity, go to bed and perform (or have performed for him) at least once and preferably twice a day a complete range of motion of that joint or joints. He should continue such a program which would include proper bed positioning, passive exercises and isometric exercises until his joint or joints are no longer painful. He should then resume a reasonable balanced program of rest and exercise.

Physical measures used to provide relief of pain and discomfort in the rheumatoid arthritic usually take the form of heat. The mechanism of action of heat is not completely understood. The application of local heat produces a degree of local sedation, dilation of blood vessels, relaxation of muscles and a degree of local extravasation of fluid. Heat should be used primarily for temporary palliation of pain and muscle relaxation to permit either voluntary or passive movement of a joint or joints. Heat should be at a reasonable temperature. Since rheumatoid arthritis is an active inflammatory disease, deep heat such as diathermy and ultrasound is contraindicated. Local or general heat should be kept at its simplest and least expensive form. Hot packs (hydrocollator packs) are popular, inexpensive and the patient can be instructed in their proper use for a home program. Paraffin baths, which have their place in a hospital program, require a certain amount of equipment, and a rather complex routine must be followed in a home program. Warm water, dishwashing and damp turkish towels may be substituted in a home program.

The purpose of heat is temporary palliation of pain in order that the muscles surrounding a joint may be capable of contracting. It is a truism that motion begets motion. An exercise program designed to maintain existing range of motion must be followed faithfully day after day to produce dividends. Patients are not always seen at the beginning of their illness when a maximal opportunity exists for a combination program of medical treatment and physical therapy. The patient may present with joints which are ravaged by disease with multiple contractures and subluxations in the posture suitable only for bed lying or wheelchair sitting. The goals in such an instance should be improvement in self-care and activities of daily living on the part of the physical and occupational

therapists, and maintenance of what joint range of motion is present in the existing joints. The physician in the care of the patient with rheumatoid arthritis should utilize the services of the orthopedic surgeon as the occasion arises, particularly as regards the possibility of further potential function in the face of deformity which can be corrected surgically. This concept of surgical correction of a part—be it surgery on the rheumatoid hand or other joints—is primarily based on function rather than appearance. Badly deformed hands can be quite useful in the presence of a freely movable thumb. Correction of posture or appearance does not guarantee improved function. Each case must be evaluated individually by the orthopedic surgeon who has had prior experience with surgery on patients with rheumatoid arthritis. At no time in the continuing care of the disease process can the physician lose sight of the patient's personal and social resources.

By definition, rheumatoid arthritis is a mean disease. By its course it engenders dependency. The individual with rheumatoid arthritis requires positive motivation in order to strive to overcome his problems which may be increasing daily. The physician who undertakes the care of the patient with rheumatoid arthritis must be willing to listen to the patient's social, economic, medical and psychological problems. In this sense he may function in the dual role of a physician and psychiatrist. The care of the rheumatoid arthritic patient can be managed by any one of a number of physician specialities: the general practitioner, the internist, the rheumatologist, the orthopedic surgeon, with the assistance and consultation of the physiatrist if indicated. However, any physician who accepts the responsibility of such a patient should be willing to institute a comprehensive medical care program which includes the factors which we have attempted to outline above. It should take advantage of all the advances in medical knowledge in an attempt to induce a remission of the disease. Physical therapy, occupational therapy, social service, psychiatric consultation and the services of the Vocational Rehabilitation counselor, all may have their place in the treatment of any one given patient in any one particular course in the disease.

In summary, the management of the patient with rheumatoid arthritis involves the management of a series of complex problems. Rheumatoid arthritis affects the patient physically, emotionally, and functionally. It may immobilize both his body and mind. No matter what physician undertakes it, the approach to the problem of management of a rheumatoid arthritic must, in order to be reasonably successful, be a total approach involving consideration of the patient as a whole, utilizing the services of physical therapy, occupational therapy, orthopedic surgery, the generalist and internist, psychiatrist and vocational counselor as the occasion arises. The cornerstone of such a program is medical control of the disease. The goals in physical and occupational therapy are based upon the above mentioned cornerstone and are (1) preservation of normal range of motion of the joints, (2) maintenance of the strength of the muscle supporting the joints, (3) improvement in the performance of those activities of daily living which are necessary for self sufficiency, (4) maintenance of general musculoskeletal facility, (5) relief of pain and inflammation, (6) support of general health and well being.

The patient who is referred to physical or occupational therapy should have a clear understanding of the goals that the physician wishes to achieve by a particular form of therapy. He or she should not be led to expect more than a well directed physical or occupational therapy program is capable of producing. Generally, a patient with rheumatoid arthritis will require a large amount of any physician's time and must be followed at intervals even though his disease is undergoing a remission. He must and should be taught an exercise and home care program in physical therapy which he should follow religiously in order to produce any worthwhile results.

The success of any treatment program in rheumatoid arthritis depends upon medical control of the arthritic process, the extent of the joint damage, the psychological integrity of the patient, the amount of functional training that can be achieved, and training in proficiency in activities of daily living as well as socio-economic and vocational factors. In this respect the treatment of rheumatoid arthritis by the physiatrist does not differ from that used by any physician in the care of the rheumatoid arthritic patient.

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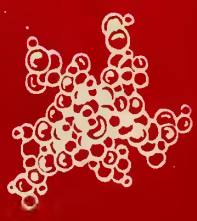
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Dosage and Administration: In women: one 250-mg. oral tablet three times daily for ten days. A vaginal insert of 500 mg. is available for local therapy when desired. When used, one vaginal insert should be placed high in the vaginal vault each day for ten days; concurrently two oral tablets should be taken daily.

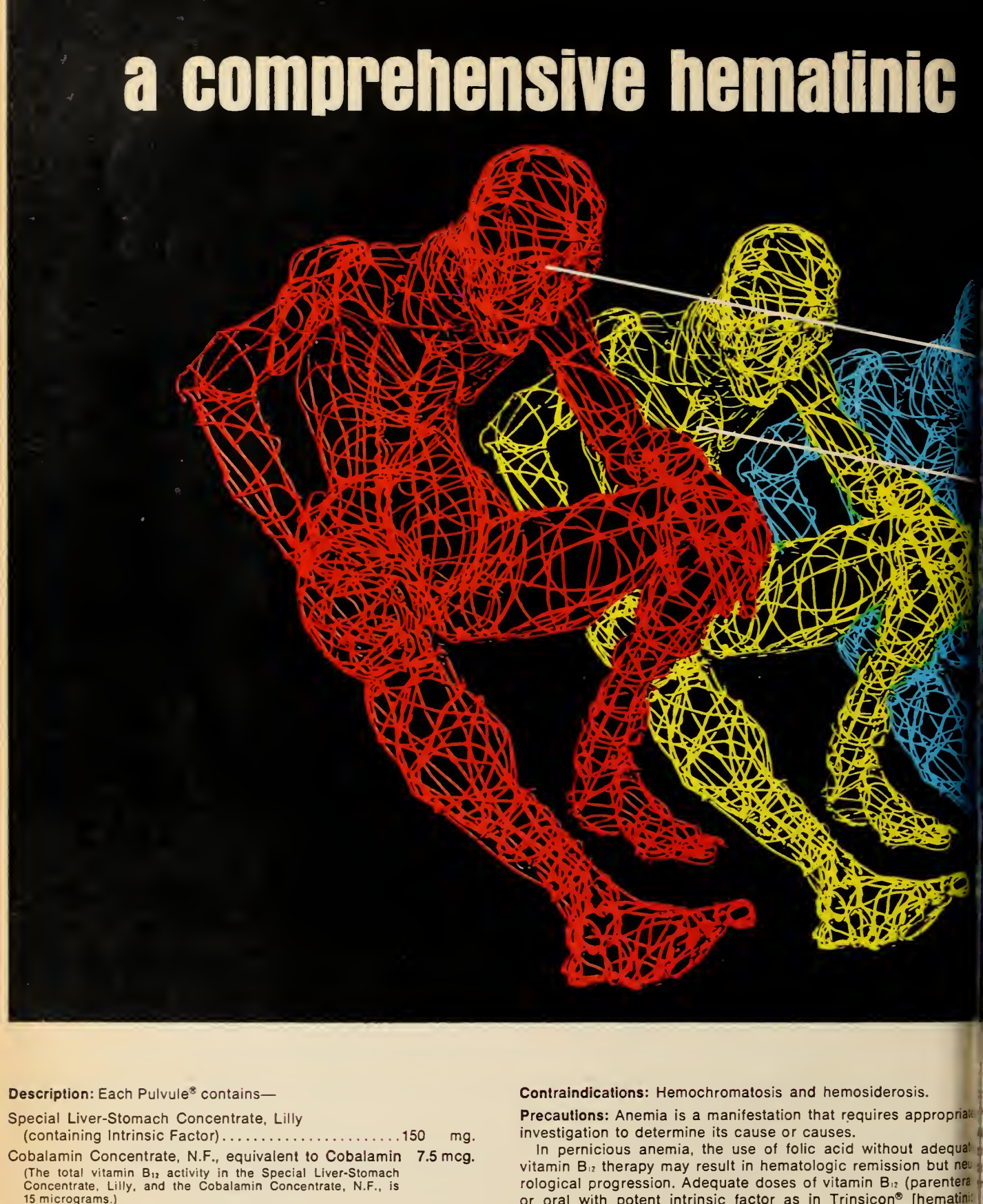
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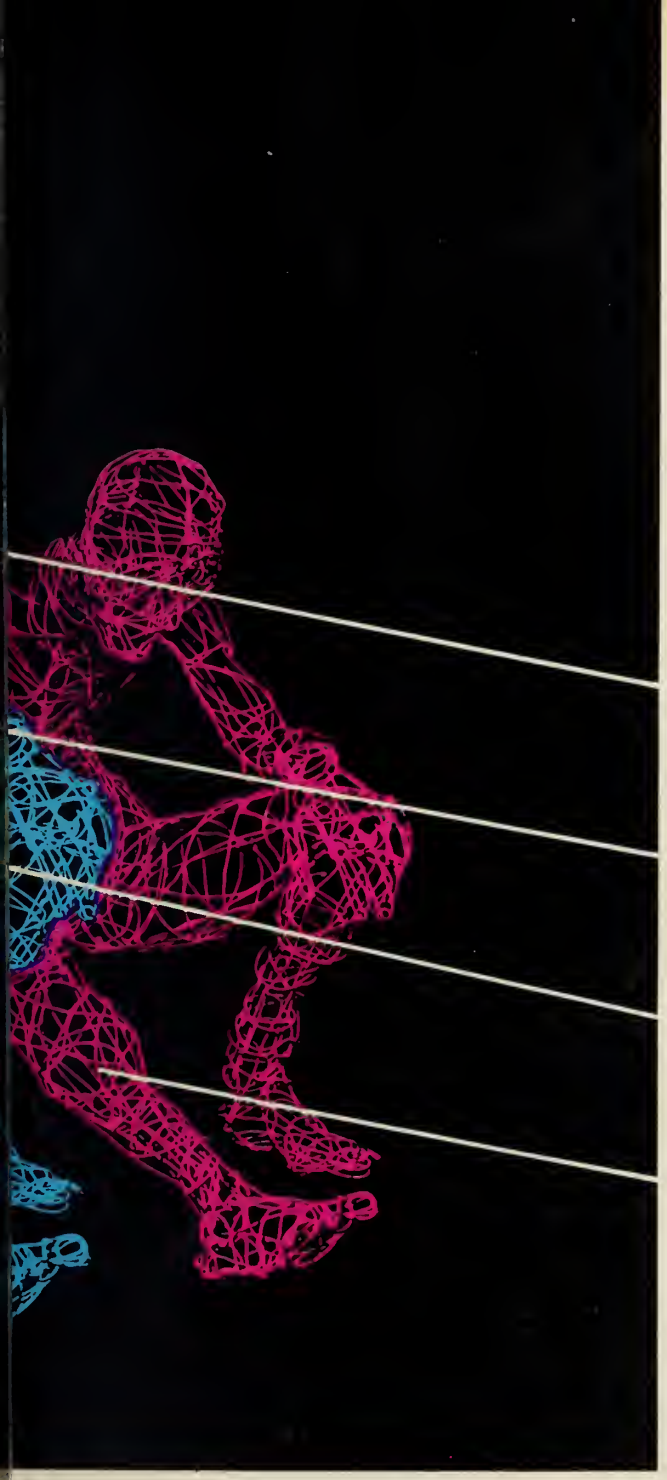
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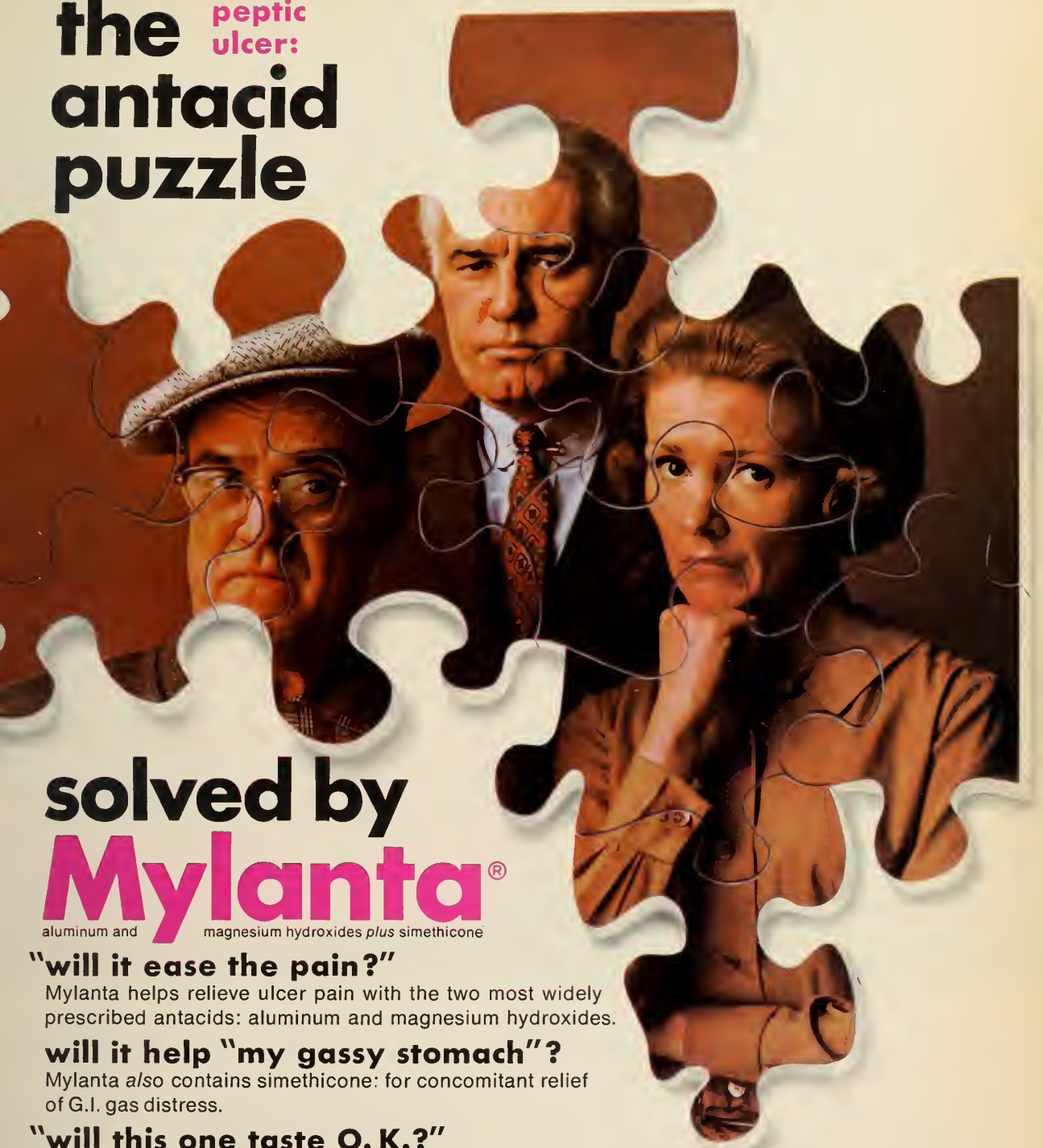
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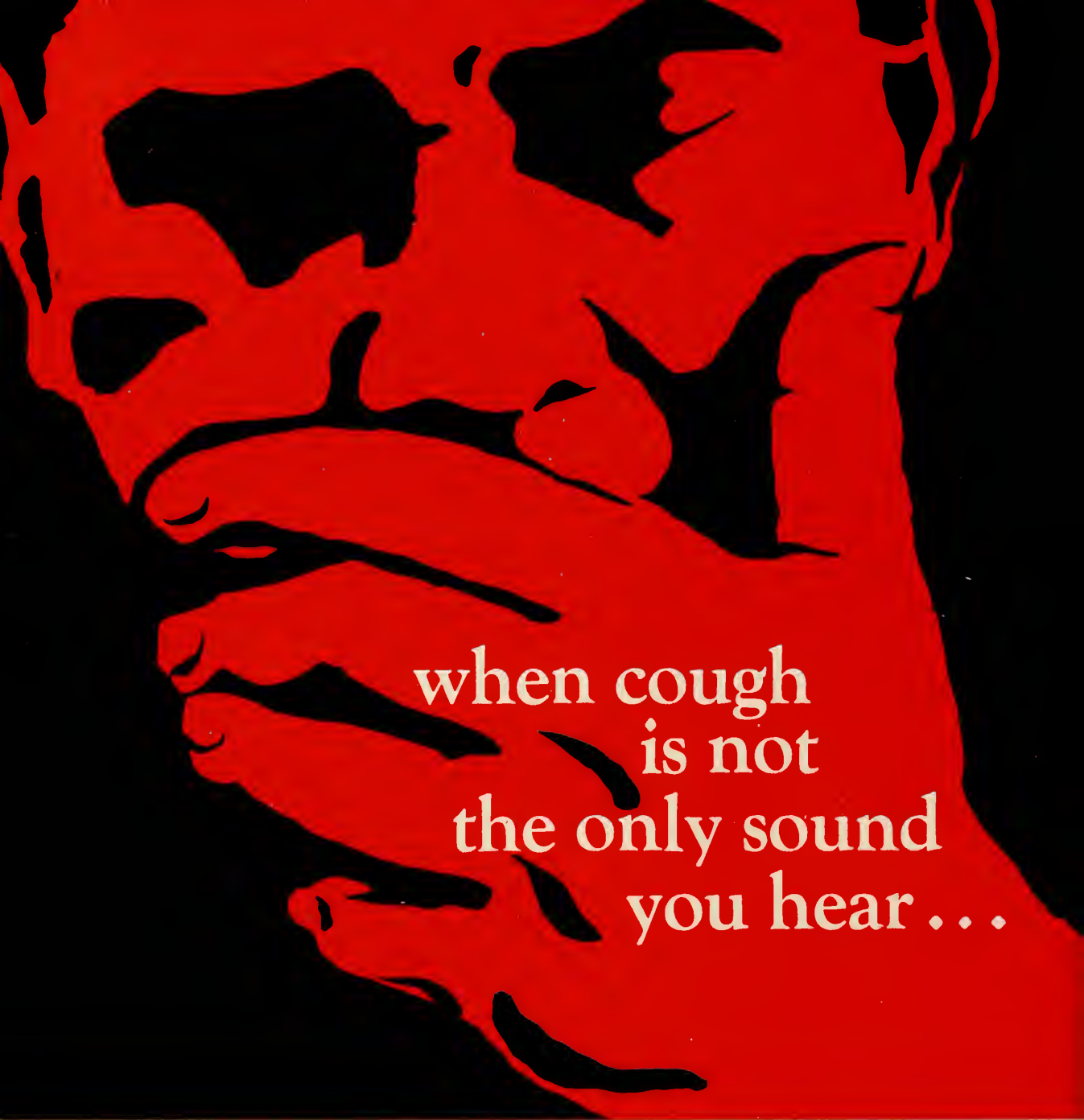
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Physicians and Their Relationship with the Hospital and Its Trustees

E. C. Bramlett

About two months ago I heard your A. M. A. President, Dr. Rouse, address a meeting in Memphis and I have incorporated a number of his thoughts in this paper and his opening example fits so well that I must quote it to you . . .

"If I hear a colleague, a physician or a layman discredit the usefulness of the modern, voluntary hospital, or express doubts about its real value in helping make available the best possible health and medical care, it would be well to refresh his memory of a quaint custom popular in Babylon some 4,000 years ago.

"In that day of barely dawning enlightenment, a sick person very often was put on his bed out in the street. Each passerby then could stop and tell the patient and his puzzled physician what he considered the best treatment for the particular problem". Well medical care has passed this point years ago, but a very modern counterpart of that example could very well be that the sick patient is the hospital administrator, because everybody, and I mean everybody, stops by to give the administrator advice for what he considers the best treatment for the operation of today's hospital.

When your President-elect, Dr. McCafferty, asked me to speak on the subject of "Physicians and their Relationship with the Hospital and its Trustees," he was kind enough to state that in his opinion the relationship between physicians, trustees and administration had been excellent at Mobile Infirmary and he wanted me to tell you about the Mobile Infirmary.

If I related to you what we had done at Mobile Infirmary, it would be of no value to you today because the avenues of communication *then* are not adequate now, because influence outside of the hospital is making policy or forcing the Board to make policy which, in many cases, is contrary to the Board's belief. These policies made by "outsiders" invade an area of relationship with the Medical Staff that in the past was

Mr. Bramlett is Administrator of the Mobile Infirmary, Mobile, Alabama. This speech was delivered at the Orientation Session at the Annual Meeting of MASA, April 18, 1968.

completely under the control of the Medical Staff.

So therefore, I will direct my remarks concerning what we are now doing, and planning to do in the future; and what I believe we all should strive to do, if we are to maintain this wonderful, modern, voluntary hospital system, which provides the atmosphere in which physicians can retain their freedom, and individuality.

Pressures are being brought to bear against the private practice of medicine, and the voluntary system of hospital, which all of us hold dear. And if we are most effectively to defend our beliefs, we must speak with a common voice. If our opponents can find cracks of disagreement in which to drive their wedges of criticisms, they will find it much easier to divide, and to conquer each of us separately. The kind of unity I am talking about will be good for all of us, as well as the patients in our hospitals.

It would be to the benefit of all concerned, if hospitals and physicians would adopt a similar public attitude, that everything done for a patient is a joint and equal responsibility of *all* that are involved in that patient's care.

Physicians and hospitals need complete unity as never before, first, for the benefit of patients—whose ultimate return to good health is everyone's prime objective; and compared with which, all other economic or philosophic considerations must be secondary. We need unity in order to face the problems of today's economic and social climate in which all elements of total health care are becoming more and more subject to criticism. This criticism creates an atmosphere of distrust and attempts to paint a picture in the mind of the general public, that *all* of the social and health problems are the *fault* of the voluntary hospital and the private physician. You have all been exposed to this discrediting. Look at some of the bureaucratic interpretations in the form of criticism and harassment that is done by individuals in painting the picture that the physician is not caring for the indigent, is not meeting his responsibilities in caring for the aged, and the only way to handle and to care for these people, would be federal programs. Look what has been done to the hospitals under the controls of Title VI, Medicare, and Medicaid. Look at the reviews that are required by Utilization Committees, fiscal intermediaries, certifications, recertifications, changes in the Joint Commission on Accreditation regarding their standards, reviews and inspections. The expanded inspections which your own department of Public Health now requires. The establishing of all sorts of guidelines that invade the responsibilities of the Boards of Trustees, whom we all know are charged with the responsibility of establishing policies. This responsibility is being carefully eroded away and invaded by guidelines, which establish policy from outside and not by the Board of Trustees, who can and have done a remarkable job working with and for the members of its Medical Staff.

Now, I say to you, what are you going to do about it? What are the hospitals going to do about it? What are the Trustees going to do about it? If we are convinced that the voluntary system is the best way for a hospital to function and that the private practice of physicians is the best way to take care of the medical needs of the people of the United States. If you agree with this as I do, then the key to this continued operation is unity and cooperation.

One of the strongest geometric figures is the triangle! We, today, are in a position to build a triangle of unity so strong that it cannot be reshaped by any external force. The sides of this triangle you will recognize as Medical Staff—Hospital Administrators—and Hospital Trustees. To blend these three knowledgeable, responsible, and independent groups into a cohesive force to withstand all who would destroy us, it is necessary that two basic things take place.

First, that the role of each group, wherever

it touches the other two, be clearly defined and fully understood by all members of the triangle.

And second, that each member group develop a genuine respect and appreciation for the abilities and responsibilities of the other two, so that each can carry out its allotted share of the total job in such a way that there is no interference with the functions of the others.

Dr. Rouse outlined as the responsibilities of a physician in this triangle as follows:

"Basic to the entire consideration is the fact that physicians are the only ones who can engage in the actual practice of medicine. This, they do, in or out of the hospital environment. And in or out of that environment, with respect to the purely professional aspects of their practice, they cannot be subjected to the purely professional aspects of their practice, they cannot be subjected to control by laymen. To that extent, they remain always as independent agents, acting with and for each individual patient.

"The nature, quality and results of their work are subject to review and to criticism, but only by other physicians, which creates an additional responsibility for members of the hospital's medical staff.

"In addition to their independent responsibilities, however, they also have obligations as members of the triangle.

"I consider it incumbent upon physicians, in their dealings with hospitals, to develop somewhat more objectively than they generally have exhibited in the past. They should work to avoid what has been called their *'gun barrel'* vision, which permits them to see only their own problems, without recognizing the broad picture of total hospital operations."

Permit me to elaborate on one point of this statement, which I enthusiastically and wholeheartedly agree with, and this has to do with the additional responsibilities for members of the hospital medical staff. You, the physicians, must understand that certain *forces* have *established rules, guidelines* and *procedures*, which *must be carried out by the hospital* and these have not been personally developed by hospital administrators to harass you, or to make things difficult for you. It is my strong personal opinion that unless you physicians *accept this additional responsibility in carrying out statutory requirements outside groups will.* And while we are on this subject may I again request each of you to re-assess your living up to all the requirements of your own Bylaws.

And speaking as one administrator, it gives me *no* pleasure to restrict a physician's admitting privileges, because the physician does not write history and physicals, because he does not initial his orders, because he does not properly recertify admissions for medicare purposes, or because he does not give a diagnosis thereby making it impossible for us to file for insurance claims. I think you all realize if we could just eliminate this "gun barrel" vision and recognize that hospitals are absorbed with, nerve-wrecking problems of personnel shortage, turnover, equipment additions, equipment obsolescence, financing for capital investments, operating expenses, payroll, constantly rising costs, all sorts of inspections and reviews, plus the greater number of problems that face any large corporation or any large institution, then we could more effectively work together. And it is really disheartening, at times, to find so much time being spent because physicians do not recognize the broad picture of total hospital operations. In today's hospital world, the medical staff must face the fact that it is very much an integral part of the institution, both legally and morally. While I do not have time to discuss the medical/legal problems please recognize, that a growing body of legal decisions in this country leaves little doubt of joint responsibility of hospitals and physicians. Hence, doctors need to be more concerned than some seem to be about the general well-being of the hospital as a whole.

One of our problems is that all too often,

the outstanding physician is so successful in his practice that he has difficulty finding time for the role of medical statesman. This vital position may *then* be filled by default by an M. D. of far less ability. The hospital is fortunate when its chief executive officer recognizes that part of his responsibility is to help the medical staff attain its full measure of effectiveness. Only with competent, seasoned leadership will the staff be able to carry its responsibility for the quality of professional care, and for helping keep the hospital abreast of the dynamic advances brought about by medical and hospital research.

Now the second portion of this triangle whose obligations I would like to discuss is that of the Board of Trustees.

Their obligations and responsibilities, are fairly obvious. But permit me to list them and think with me as we determine how they may be improved to make this triangle invulnerable to those forces that would destroy us.

It is the trustees responsibility to provide an *atmosphere* in which physicians can provide quality medical care without the disadvantages of any kind of pressure or influence.

Secondly, to provide an atmosphere in which the opinions of physicians who practice in that hospital not only *are welcome* but *are sought* with *respect* to the establishment of procedures and policies that will lead to the best patient care.

Thirdly, that the Trustees will provide a physical environment that is most conducive to the comfort and well-being of patients.

Fourthly, to provide for the continuing examination of the care provided within their institution by the hospital personnel, and—through the medical staff—an examination of the type of medicine practiced by physicians within that hospital, and that these standards be judged in accordance with today's medical care and not that of a generation ago.

Fifth, Trustees are responsible for the fiscal solvency of the institution.

Sixth, they are responsible for doing all that is within their power to keep the cost of hospitalization as low as possible.

Seventh, Trustees should become thoroughly familiar with medical problems, and genuinely sympathetic towards seeing that they are solved in the most effective possible way.

Now to strengthen this segment of the triangle, it would be my opinion that the Trustees should evaluate themselves against this seven point criteria. To truly know that they are accomplishing these purposes. To truly know that they are fulfilling the responsibility of trusteeship. To truly know what is going on within their hospital, and to become familiar with the medical problems, and hospital problems in all respects, and not to judge a successful hospital on its fiscal solvency alone. In all of these points, your personal, informal contact with trustees away from the hospital could be of real value.

Now let's look at the third member of the triangle—the hospital administrator.

First and foremost, it is the responsibility of the administrator to carry out the policy determinations of the trustees, and so consequently this administrator should immediately accept as his responsibility, the seven previous points, because the administrator is the agent of the governing board.

Two, it is the responsibility of the administrator to develop a hospital team of personnel that is properly motivated with a genuine desire to render the best possible patient care to all patients that are admitted to the hospital by physicians of the medical staff. This broad terminology, of course, includes the best possible safety for the patients, and the best possible adequacy of patient care, with the best possible equipment, in short, to supply the best tools for every employee so that every employee can work with a greater degree of efficiency.

Third, it is the responsibility of the administrator to develop good lines of communication between the medical staff, the board of trustees, and all hospital personnel.

Fourth, it is the responsibility of the administrator to become involved in community planning of hospital facilities and proper utilization of all facilities and all trained personnel within the hospital area. Comprehensive health care planning, at the moment, is number one on the list of jobs that must be thoroughly and completely done by the hospital administrator.

Fifth, it is the responsibility of the administrator to be thoroughly familiar with all of the legal responsibilities now facing hospitals in the form of Title VI, Title VII, Wage and Hour Laws, Medicare, Medicaid, State Health Licensing Laws, and to operate his hospital within the scope of all laws, and to be thoroughly familiar with the difference between opinions, suggestions and even *guidelines that may or may not truly be the law.*

Sixth, it is the responsibility of the hospital administrator to recognize the influence the public is having as they look at hospitals in a new light. Currently, hospitals are being considered as utilities and the public looks upon health care as a right. Therefore, the public should be informed as to what is going on within our hospitals, so that they will truly understand that they are receiving a quality product, and that one of the prime reasons that the public is receiving a quality product is because they still have *the right to be treated by physicians of their choice.* This choice must be preserved and no door be opened or breakdown occur that would permit the interference with this priceless heritage, *"the right of a patient to select the physician of his choice."*

Now let's look critically at this hospital administrator. First and foremost, this administrator should be qualified, academically, mentally and physically. And not just be hired, because of political favoritism or because he was an ex-mailman or an ex-used car salesman and is a friend of someone on the Board of Trustees. To help alleviate this problem, the hospital administrators of the State of Alabama are developing a licensing law, with certain criteria necessary before individuals can be licensed as hospital administrators, and we expect to present this to the legislature during its next session.

Secondly, this administrator must expand his horizon, and no longer can look only at his hospital operation, he must communicate openly and freely with the other hospital administrators in his operating area.

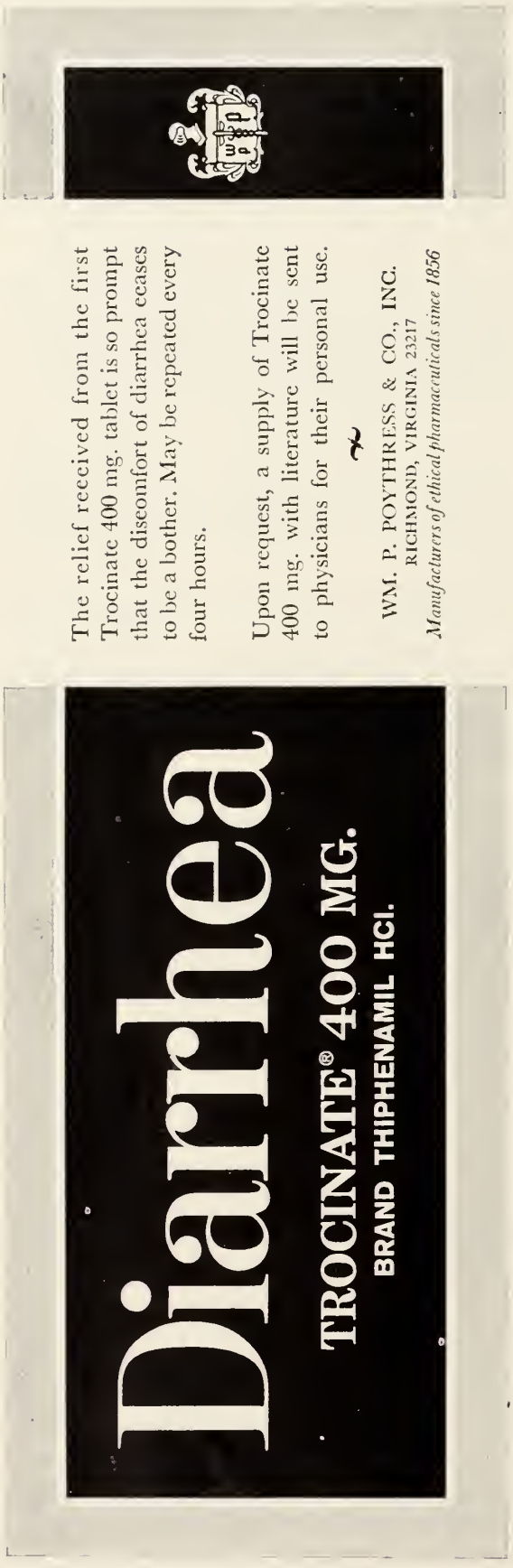
Thirdly, this administrator must develop instaff training programs to have available the best possible, professional and non-professional help for all departments within the hospital.

Fourth, he must be knowledgeable about all outside legislation, to be able to keep the Trustees and the Medical Staff fully apprised of what effect these forces are having upon the hospital.

Fifth, and perhaps the most important of all, he must earn, he must gain the admiration, and the respect of the entire Medical Staff, and the entire Board of Trustees.

Individually, I have described what I believe are the purposes and the functions of this triangle and have made comments on each section as to how their relationships can be improved.

Jointly now, think with me as to what is necessary if we are to reach our primary goal of *preserving the system of free private medical practice, and the concept of voluntary hospitals.* Both of these are under heavy attack, and the pressures are not likely to lessen. There are constant increasing demands from elements of our government, from many social groups, and from certain public sections. These demands are for centralization of authority over health care, for federal subsidy to replace individual responsibility for purchasing one's own care, for prepaid group practice in and out of hospitals conducted by salaried physicians, for the



replacement of consumer decisions by government regulations, and for placing this health care system away from the free market place, to be controlled by men who somehow have been blessed with "superior" social conscience, and who will guarantee that the fruits of the health system will be equally and simultaneously available to every facet of our wide spread society. One of the most important things we need to combat those who would destroy us, *is good communication in the broadest sense.* Now how do you develop good communications between administration, medical staff and the board of trustees, and are *sure* that these lines of communications remain open at all times?

One way is to have a Joint Conference Committee that meets, discusses and shares all ideas. Some of you have Joint Conference Committees, but they don't function and don't accomplish their purposes.

Another area where communications can be improved would be that the President and the President-elect of the Medical Staff be invited to attend every Board of Trustee meeting, and be invited to participate. The President and President-elect of the Medical Staff are the elected representatives of the staff and this will eliminate the possible dangers of conflict of interests, or of possible prejudice in favor of a particular department. The members of the Board of Trustees would refer to these physician members because they are elected by the Medical Staff and thereby represent the staff and not on the basis of an individual with personal desires. Because of this atmosphere physician members could not become suspect by the other members of the Medical Staff. All of the disadvantages of physicians on boards could be eliminated, and all the advantages enjoyed by having the President and President-elect serve in an advisory capacity.

The third way in which communications can be developed would be to invite the various chiefs of the sections of the hospital to visit the Board of Trustee meetings, and if

possible, to present a report of their departments to the Trustees. This would give an educational advantage to the Trustee, and it would also give the physician an opportunity to observe the trustees in action.

Fourth, one hospital has made excellent progress in strengthening its relationship with Trustees, Staff and Administration. This institution schedules a 1½ day meeting of the members of the governing board, medical staff executive committee and top hospital management personnel at a resort area away from the hospital. (Wives of the attendees participate.) Each group reports to the others, detailing its activities and objectives. Recently retired, former head of the Joint Commission on Accreditation of Hospitals, Dr. Babcock was a special guest at one recent seminar. His function was to start the seminar off on a high plane by stressing the great need for close cooperation and harmony between the board, staff, and management. He also summed up the reports at the conclusion of the sessions.

The seminar began with a social hour, followed by Dr. Babcock's opening remarks. The following day was devoted to reporting sessions. This gave hospital management personnel an opportunity to report in some depth—in a modest but comprehensive manner—on the accomplishments of the departments they supervise. It was a real eye-opener to many board members, staff members and their wives. Governing board officers helped to underscore the importance of the management function in covering broader aspects such as capital financing, and planning for expansion.

The reaction of all the participants was favorable. There is greater understanding among all the key people in the organization, less likelihood of serious friction developing, and deeper appreciation of the function of management.

Fifth, all members of the Medical profession, as well as the members of the hospital management and Board of Trustees should join publicly and with vigor in the defense of our free enterprise system of health care. There is not the slightest doubt in my mind that if the public was told again and again, about the quality of care which is being rendered by the medical profession and, the hospital system, that the public itself, would then recognize that this care is of the highest level of quality, and the most reasonably priced, and can be provided to an ever-increasing population in a context of free competitive enterprise. And I mean that this should be done openly, not just in the doctors' lounge or behind the closed doors of the Trustees' meetings. But we must tell our story.

Put this triangle and its three points together with a very clear understanding as to what is the objective and if you share with me that the objective of this triangle is to preserve this system of free, private medical practice, and the concept of voluntary hospitals. Then let us all place this objective so firmly in front of us that there can be no misunderstanding and we can united, attack these outside forces and win the admiration and respect of a generation yet unborn. If we don't we will see the collapse of the triangle and the creation of a weak, lopsided quadrangle with the federal government on top and the development of a socialistic medical system that will produce a substandard of care for the citizens of the United States.

Calendar of Annual Meetings

Medical Association of the State of Alabama

1969, April 24-26, Carriage Inn, Huntsville

1970, April 30-May 2, Mobile

1971, April 22-24, Birmingham

1972, April 20-22, Montgomery

1973, April 18-21, Mobile

(Continued on Page 67)



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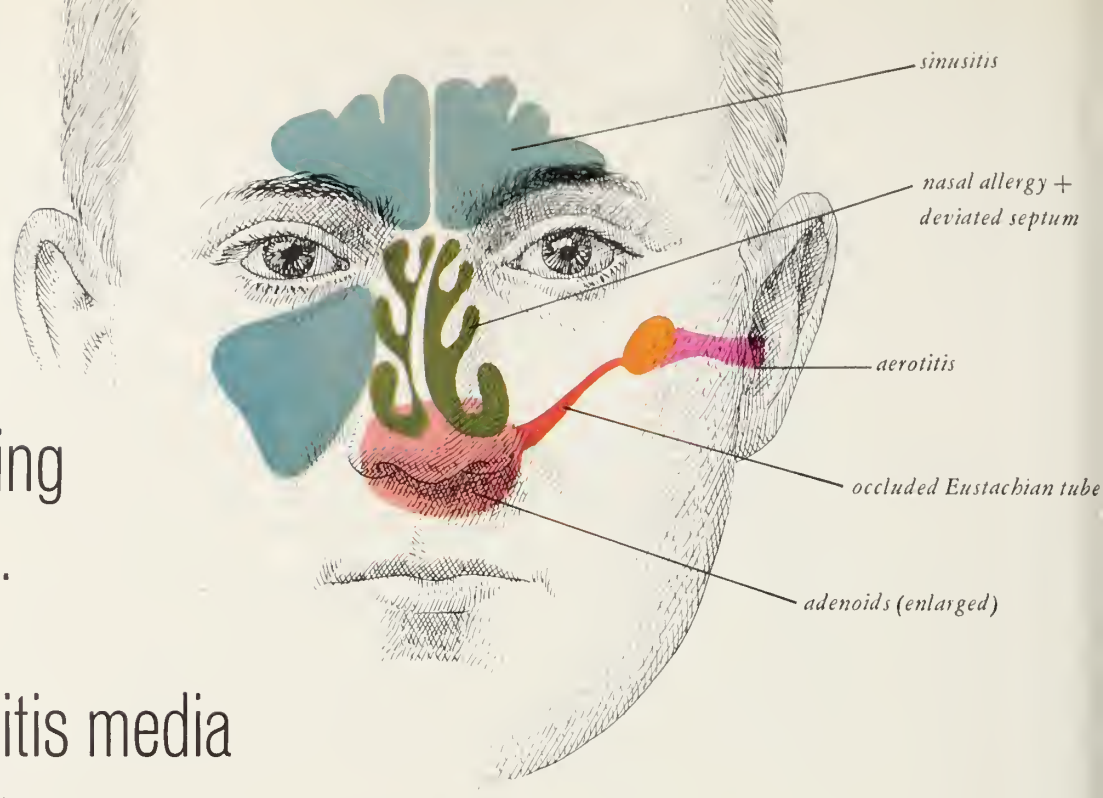
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this issue:
serous otitis media
an original article
by Robert H. Lofgren, M.D.



the complaining earache... key to serous otitis media

Robert H. Lofgren, M.D.
Associate Surgeon, Massachusetts Eye and Ear Infirmary, Boston, Massachusetts

Serous otitis media is probably the most common ear problem in children, especially in the wintertime. Diagnosis is usually easy in adults, but may be quite difficult in children, especially the very young child where one has to depend almost entirely on the physical findings.

The symptoms of serous otitis are a fullness in the ear, a mild hearing loss and mild earache. The earache can best be described as a "complaining earache" instead of a "screaming earache" as found in purulent otitis media. A young child may be irritable and pull at the ear. In milder cases, and as the ear recovers, gurgling and popping noises can be heard in the ear.

On examination one may see a yellow tympanic membrane and if a fluid level is present the diagnosis becomes easy. However, the eardrum may be dull gray, or slightly pink, or even perfectly normal. Pneumomassage using a Siegle otoscope or a closed-head electric otoscope must be done on both ears, otherwise the diagnosis will be frequently missed. Attempted movement of the drum with the pneumatic otoscope produces either a sluggish motion of the drum or no motion at all instead of the easily movable normal drum. The Rinne test is negative and there is a 15-20 decibel conductive hearing loss. The bone conduction may be better than normal and an air-bone gap may exist even with the air conduction within normal limits. Occasionally one finds a false nerve deafness on the audiogram when thick glue-like fluid causes immobility of both the oval and round window. Both conditions return to normal when the fluid is removed, but they make the interpretation of screening audiograms very difficult.

There is no single cause for serous otitis. One factor always present is blockage of the eustachian tube, but this alone is not enough to produce fluid. There must also be an inflammatory reaction. Blockage of the eustachian tube may be caused by many conditions. In children the most common cause is enlarged adenoids. In the summer the next most common cause is allergy. Upper respiratory infections or influenza are common causes in the winter. Nasal allergy, acute and chronic sinusitis, nasal septal deformity and cleft palate can all cause eustachian tube obstruction. Some children may have a congenitally small eustachian tube, but fortunately they usually "grow out of the problem."

The first sign of a nasopharyngeal tumor is often a serous otitis. One must always rule this out in any adult who later in life develops repeated or persisting serous otitis. Causes sometimes overlooked are nasogastric tubes after surgery, simple obesity and cardiorenal disease, which may produce congestion in the mucosal lining of the eustachian tube. In recent years we have been seeing a new cause—acute otitis media, where the patient is adequately treated with antibiotics but where drainage has not been

established either through the eardrum or down the eustachian tube. A sterile exudate is left in the middle ear.

The inflammatory response may be caused by a marked negative pressure as in air otitis from flying, or it may be from a mild bacterial or viral infection in the middle ear. Serous fluid is a good culture medium and will frequently go on to purulent otitis media, especially if the original blockage was caused by an infectious process such as acute rhinitis or adenoiditis. When the infection heals there may be scarring in the middle ear mucosa. Mucous glands develop in this tissue and pour out a thick mucoid material. This ear usually looks normal until a pneumatic otoscope is used. The objectives in treating serous otitis are to remove the obstructing agent and to provide drainage from the middle ear. Often this can be accomplished by decongestants and nose drops. If large obstructing adenoids are present they should be removed. Sinusitis should be treated with oral decongestants or nose drops, plus antibiotics where indicated. Nasopharyngeal tumors should be treated. Allergies should be treated with antihistamines and, where indicated, by desensitization.

If the fluid does not clear with medical treatment within a week or two, a myringotomy should be done. If there is a question of active infection or if the fluid looks purulent, as is seen at the conclusion of acute otitis, cultures are taken. On adults this can be done in the office without anesthesia. It is no more painful than an intravenous needle for a blood test. A good safe topical anesthetic has a tremendous psychological value to the patient. Children under the age of 1 require no anesthesia. Between the ages of 1 and 3 anesthesia is not absolutely essential although a general anesthetic may be used to avoid the child's possible mistrust at follow-up examinations. I usually do the myringotomy at the same time as the adenoidectomy if the adenoids are enlarged. Once drainage has been established with decongestants or by myringotomy, positive pressure inflation of the middle ear is invaluable in forcing out the serous fluid and keeping it from reforming. The patient can do this himself by performing the Valsalva maneuver. This should be done several times a day, by taking a deep breath, holding the nose and blowing hard against the closed lips for a second or two.

In resistant cases where the fluid reforms as soon as the myringotomy heals, small polyethylene tubes are inserted through the myringotomy site. Insertion of the tubes, even in adults, usually requires an anesthetic. Good anesthesia can be obtained by infiltrating the canal wall with a local anesthetic, using a #27 needle. Once inserted the patient has no sensation of the tubes' presence. Be careful to caution the patient or parents not to allow any water to get into the ear canal while a myringotomy is open or a tube is in place. Water can be kept out by a pledget of lamb's wool in the ear canal or a cotton pledget thickly coated on the outside with petroleum jelly. I check these patients a week after a myringotomy to be sure it is healed and at two month intervals until the tubes have fallen out, usually within three to six months after insertion.

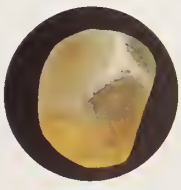
The mucoid type of fluid is so thick and tenacious that it is appropriately called a glue ear. It is aspirated only with difficulty through the eardrum, and occasionally must be removed through a tympanotomy. This thick, glue-like fluid is prone to recur, as the myringotomy usually heals long before the mucous membrane has returned to normal. Repeated myringotomies, as many as ten or twenty, were formerly required for this condition. Now polyethylene tubes are inserted initially when this thick, glue-like material is found. At times a subacute mastoiditis may accompany the serous otitis, which will necessitate a simple mastoidectomy before the condition can be eradicated. Usually the thin serous fluid readily responds to decongestants or to a myringotomy and removal of the eustachian tube obstruction. Occasionally, however, even serous fluid will repeatedly reform. For this, resection of the tympanic plexus of nerves which lies on the promontory of the middle ear has been carried out, as the tympanic branch of the glossopharyngeal nerve is the secretomotor nerve to the ear.

Failure to diagnose serous otitis is the most common cause of the recurrent, almost continuous otitis me-

Otoscopic Views



Normal



Acute Serous



Acute Purulent



Chronic Serous

dia seen in young children. In these cases a myringotomy will frequently provide a long-term cure without adenoidectomy or any other surgery. Failure to do this may allow the condition to go on to acute or subacute mastoiditis. Adhesive otitis media with scar tissue binding down the ossicles or tympanosclerosis may also result with permanent impairment of hearing. The prognosis for hearing with adhesive otitis or tympanosclerosis is usually poor. If the adhesions are removed, they reform, and the same is frequently true of tympanosclerosis even after a tympanoplasty. For many of these people a hearing aid is the only solution. The constant negative pressure in long standing serous otitis media may draw in either Schrapnell's membrane or the posterior superior portion of the eardrum forming a pocket to cause a chronic otitis media with cholesteatoma, which may not become apparent until twenty or thirty years later.

The non-medical complications of improper diagnosis or treatment may be even more serious. The irritable child, the frequent bouts of acute purulent otitis media with pain and fever, the expense of antibiotics and doctors, and the time lost from school or work affect the entire family.

In summary, serous otitis has many causes. There is a blocking of the eustachian tube and an inflammatory reaction in the middle ear mucosa, the latter usually caused by a mild infection. The treatment is to provide immediate drainage by decongestants and where necessary, by a myringotomy. The obstructing agent must be removed by surgery if it is adenoid or by oral decongestants, and antihistamines or nasal spray if it is an upper respiratory infection or allergy. Occasionally resistant cases require plastic tubes placed through the eardrum or other more radical surgery. Failure to treat properly leads to hearing loss which may be permanent, repeated acute otitis media or possibly even chronic otitis media with cholesteatoma.

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Bridging the Gap in Medicine

Albert P. Brewer, Governor of Alabama

It is a privilege for me to have the opportunity to speak at this luncheon of the Alabama Medical Political Action Committee. It seems appropriate for me to express my appreciation for the confidence shown in me by the medical profession as evidenced by your support in my campaign for Lt. Governor in 1966, and it has been a source of great personal satisfaction to me to view the progress which we have made, working together, in medical facilities in Alabama.

I also want to commend you on the increased involvement of physicians and their wives in political activities. For many years I was puzzled and dismayed by the apparent lack of interest on the part of many physicians in what was going on in government at the state and national levels—I suspect, and I imagine that you share my feeling, that many of the problems confronting organized medicine today are due at least in part to medicine's lack of involvement in political activity for so many years.

Little will be accomplished by telling you that you were late in moving into the political arena—almost too late. If you doubt this, then look no further than the federal laws now in effect relating to medicine. Had I told you ten years ago the extent of federal regulation and control over medicine which would be in effect today, many of you would simply have shrugged and told me "that's ridiculous—it can't happen here" but it has happened here, and I predict that it will get increasingly worse unless the physicians of Alabama and the nation become increasingly active in political affairs.

If what I am saying sounds like a sales pitch for membership in ALAPAC, then I plead guilty, but it actually goes far beyond that—my point is that everyone, physicians included, should and must reflect a greater interest in the activities of government whether at the local, state or federal level. Interest leads to concern—concern leads to involvement—and involvement is the only totally effective way to patricipate in government.

I regret that it was impossible for me to be with you on yesterday when you honored Her Excellency, Governor Lurleen Wallace. I recall that a year ago, speaking at this very same function, Governor Wallace expressed the feelings that perhaps no Governor in the history of Alabama felt a closer bond to the medical profession than she, with the possible exception of Governors William Wyatt Bibb and Russell Cunningham, both of whom were physicians. It was not necessary for her to make those two exceptions—without question her administration has reflected greater concern and greater compassion for the health of the people of this state than any other administration in Alabama's history.

And to those people who think public officials often make promises which are never fulfilled, I would suggest they reread Governor Wallace's speech to this ALAPAC luncheon a year ago and compare her words of 1967 with her record of today.

I hope you will not feel I am presumptive if I take a few minutes today to voice this layman's opinion on what I consider to be one of the major problems facing the medical

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(Editor's Note: On April 19, 1968, Albert P. Brewer, then the Lieutenant Governor of Alabama, was principal speaker at the Third Annual ALAPAC luncheon held in conjunction with the 107th Annual Session of the Medical Association of the State of Alabama. Just 18 days later, upon the death of Governor Lurleen Burns Wallace, he assumed the helm of the highest office of the State. Because of his long-standing friendship toward the medical profession and also because the views stated in his speech may be construed as his policies toward health matters during the remainder of his term, the full text of his address is printed herewith for the information of all physicians.)

profession in 1968. I would preface this diagnosis by saying that I have been truly astounded by the tremendous advances made in medicine in recent months and years. It seems that a week seldom passes that some new treatment procedure, some new surgical technique is perfected, to be used in the continuing fight against sickness.

But what concerns me, and what I know concerns many of you, is the fact that in many instances there is a tremendous lag between the scientific breakthrough on the one hand and the actual application of this breakthrough in the treatment of the patient.

To put it in the simplest terms, what I feel is greatly needed in medicine today is a bridge—a bridge which links the research centers with the practicing physician and his patient. It is of little consequence that significant medical advances are made in the laboratories if these advances are not applied, and swiftly applied, to the patient. After all, is not this the very reason for the existence of the medical profession—the rendering of the very best health care possible to the sick?

There are no doubt several routes which can and should be followed in bridging this gap, but I feel none is more basic than an expansion in and improvement of medical education. We need more doctors today, we also need better doctors.

The primary responsibility for the training of physicians to serve the people of Alabama rests with the University of Alabama Medical College.

Since the establishment of the Medical College of Alabama in Birmingham in 1945, this institution has enjoyed a phenomenal growth under inspired leadership until today it is recognized as one of the leading medical centers in the Nation. The Journal of the American Medical Association in its issue of October 30, 1967, published a rating of the South's medical schools by the medical deans. The consensus of the deans was that Duke University is on top now, but advancing most rapidly in the entire South is the University of Alabama.

The University of Alabama Medical Center has as its primary objective the training of qualified health personnel to meet the health needs of the people of Alabama.

Those of us in government have taken great pride in the dedication of the personnel of the Medical Center toward this objective.

And I should point out that the Medical Center is not simply a local project in Birmingham. For many years the College has worked closely with the staff of Mobile General Hospital in the internship and residency program at Mobile General maintaining a schedule of faculty who rotate through teaching positions in Mobile. Programs are also in effect in Baldwin County and Fayette County, and active teaching programs are underway in Alexander City, Gadsden and other parts of the state. This is an indication of the strong feeling of the individual faculty members toward their responsibility to the state.

We get an impression of the quality of this program from the relative standing of our students on national examinations where they compete with students from all other institutions, and these results indicate that Alabama students rank in the upper third of the United States—these are our future physicians and dentists.

Perhaps the most vivid example of the outstanding program being carried on at the Medical Center has been the effective recruitment of renowned faculty members to Birmingham. By way of illustration I would cite only a few examples which could be duplicated many times. As you know, one of the major departments in the Medical College is the Department of Surgery. Unfortunately, the University lost its first full-time Chairman and Distinguished Professor of Surgery, Dr. Champ Lyons, two years ago. Following this unfortunate loss, a distinguished blue ribbon committee was appointed to make recommendation for a suc-

cessor to Dr. Lyons. The committee consisted not only of outstanding faculty members from the University of Alabama, but the Chairman of the Department of Surgery at McGill University as regular members of this committee. After screening the most outstanding surgeons from throughout the United States, their number *one* recommendation was Dr. John Kirklin. There was, of course, grave concern as to whether or not the University would be able to recruit Dr. Kirklin. He was at that time the Head of Surgery at the Mayo Clinic in Rochester, Minnesota. In addition, he had already declined similar positions with comparable salary levels at the Johns Hopkins Medical School and Stanford University School of Medicine. Nevertheless, following a policy of attempting to recruit the most outstanding individuals that could be found to every position, Dr. Kirklin was invited to visit in Alabama and after evaluating our state and University Medical Center, he elected as you know, to join the full-time faculty of your Medical Center. The repercussions from this appointment are still being felt throughout the United States. Not only has Dr. Kirklin continued the high quality of surgical educational, research and service program initiated by Dr. Lyons, but he has succeeded in expanding this program into a number of new areas. This individual, together with Dr. Reeves and Dr. Harold Dodge (another new and important addition to the faculty), are largely responsible for the announcement last year by the National Heart Institute that a grant to the University of Alabama Medical Center in the field of heart disease had been approved with the highest priority and the largest annual sum which had ever been given by that institute. This one grant alone amounts to $1.7 million per year coming into your Medical Center. More recently, we have added to the X-ray department the most renowned heart radiologist that I know of in any institution. This physician elected to come to Alabama although he was sought after by many other universities, including Harvard and Emory, among others, because he was attracted by the energetic and dedicated faculty and students at your Medical Center. We are enthused by the decision to come to Alabama of Dr. Luther Longino, formerly director of the training program at Children's Hospital in Boston, whose reputation in pediatric surgery is without parallel. The University was successful recently in enlisting Dr. Josiah Macy of New York City, one of the foremost authorities in computer technology in the world. I could cite scores of other such examples, but they would all serve to illustrate the point that the University is attempting to bring to Alabama the most competent people to be found anywhere to provide superior health education and health service for the people of this state. And what is more important, we have been successful in attracting these people to Alabama. Each such individual not only provides education and service to this area, but also attracts millions of dollars into the state from grants, contracts and awards. Although they must compete with other scientists from all over the country for these funds, they are successful because of their outstanding competence. Such funds now make up 25% of the budget of the Medical Center and are doubling every three years.

But realizing that the majority of the future practitioners of medical, nursing, dentistry and other health professionals for Alabama will be provided by the University of Alabama Medical Center, we should be aware of deficiencies in our program where they exist.

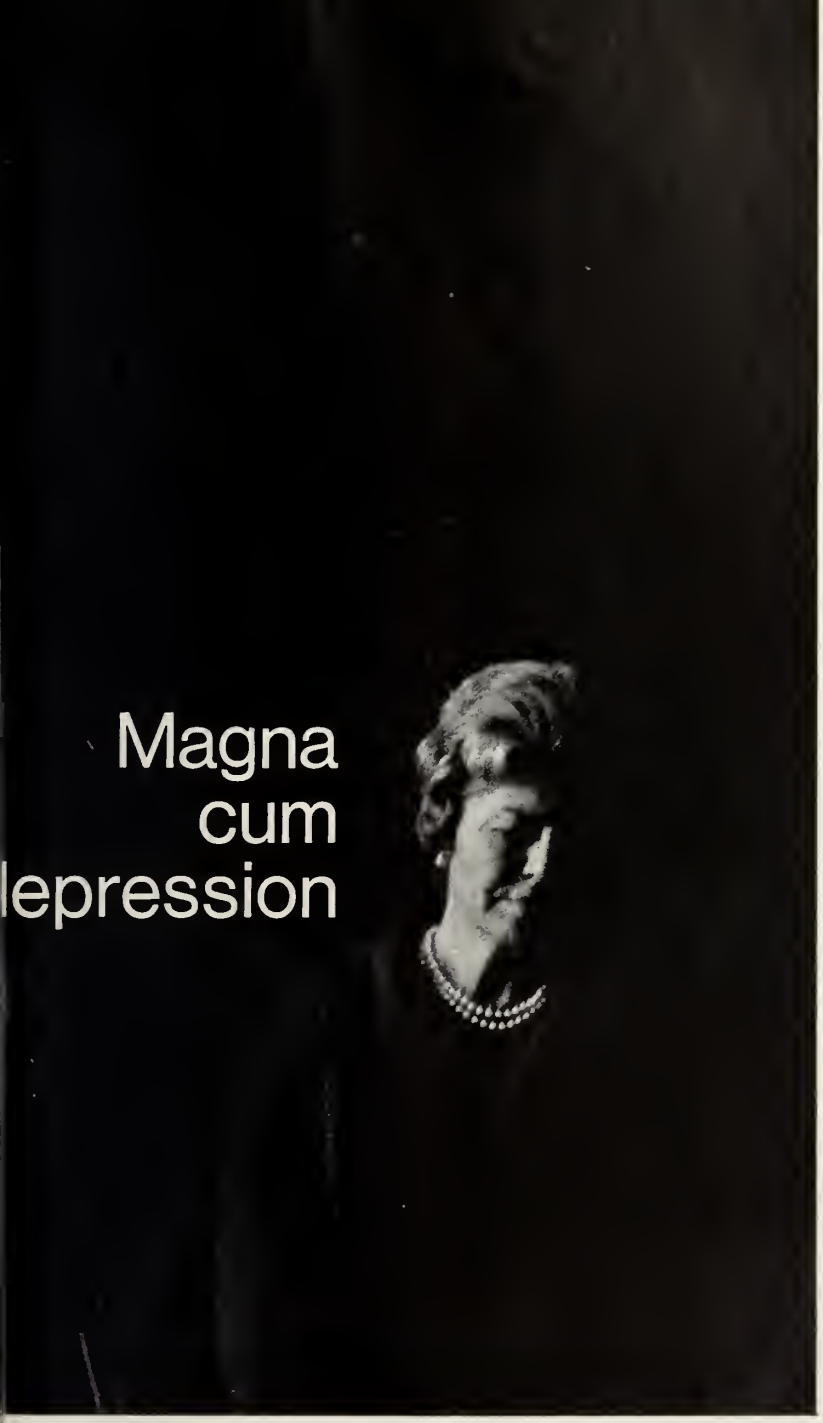
There are areas where we have been unable to move forward because of lack of funding, where we have no full time faculty members and only limited programs—thus while we have outstanding programs in particular areas we have not yet reached the objective of excellence in all areas which the people of this state deserve. Not only are we failing to provide complete training in these areas, but also we are educating far too few

(Continued on Page 72)



Tofrānil®, imipramine hydrochloride

Indications: Tofrānil is recommended for the treatment of depressive states of diverse psychopathology.
Contraindications: The concomitant use of this agent and monoamine oxidase inhibiting (M.A.O.I.) compounds is contraindicated. Hyperpyretic crises or severe convulsive seizures may occur. Potentiation of adverse effects can be serious or even fatal. An interval of at least 7 days after M.A.O.I. therapy has been discontinued should be allowed before this drug may be substituted. Initial dosage should be low, increases should be gradual, and the patient's progress should be carefully observed.
Warning: Clinical reports have suggested that there may be a risk of teratogenesis associated with the use of this compound during the first trimester of pregnancy. Unless, in the opinion of the prescribing physician, the potential benefits outweigh the possible risks, it should not be used during the first trimester of pregnancy. Cardiovascular complications, including myocardial infarction and arrhythmias, have occasionally occurred in susceptible individuals. Patients with cardiovascular disease should be given the drug only under careful observation and in low dosage.
Precautions: Since suicide is always a possibility in severely depressed patients and one which may persist until significant remission occurs, such patients should be carefully supervised during early treatment. Some severely depressed patients may also require hospitalization and/or concomitant electroconvulsive therapy. Because of its anticholinergic effect, caution should be observed in prescribing the drug for patients with increased intraocular pressure.
In rare instances, transient cardiac arrhythmias have occurred in hyperthyroid patients and in patients receiving thyroid medication when this compound was added to the regimen.
Imipramine may block the pharmacologic activity of guanethidine and other related adrenergic neuron-blocking agents.
The drug is not recommended at the present time in patients under 12 years of age.
Adverse Reactions: Dryness of the mouth, tachycardia, constipation, disturbances of accommodation, sweating, dizziness, weight gain, urinary frequency or retention, nausea and vomiting, peripheral neuritis, mild parkinson-like syndrome, tremors, rare cases of falling in elderly patients, confusional states (with such symptoms as hallucinations and disorientation), activation of psychosis in schizophrenics and agitation (including hypomanic and manic episodes which may require dosage reduction



For him, commencement.

For his mother, the beginning of his career may seem the end of hers. The end of feeling needed and useful. The beginning, perhaps, of a pathological depression.

Tofrānil can often relieve the symptoms of her depression. If it can relieve her mental anguish, you may be able to help her graduate into a new and fruitful life of her own.

Tofrānil could be her commencement, too.

Tofrānil® Geigy
imipramine
hydrochloride

in depression

The use of Tofrānil in patients receiving M.A.O.I.'s is contraindicated.

In patients with cardiovascular disease, hyperthyroidism or increased intraocular pressure; in those receiving anticholinergics (including antiparkinsonism agents), thyroid medication or adrenergic neuron-blocking antihypertensive agents; and in those in the first trimester of pregnancy, the precautions discussed in the Prescribing Information should be carefully observed. Although toxic reactions severe enough to require discontinuation of Tofrānil are uncommon, please refer to the Prescribing Information for a description of such instances when discontinuation may be necessary.

/or addition of a tranquilizer or porary discontinuation of the drug, eptiform seizures, orthostatic otension and substantial blood ssure fall in hypertensive patients, ɔura, transient jaundice, bone mar- depression including agranulocy- s, sensitization and skin rash uding photosensitization, eosino- ia, and mild withdrawal symptoms udden discontinuation after pro- ed treatment with high doses. asional hormonal effects (im- nce, decreased libido, and estro- c effects) may be observed. pine-like effects may be more ounced (e.g. paralytic ileus) in eptible patients and in those g anticholinergic agents (includ- ntiparkinsonism drugs).
atient Adult Dosage: Initially, g. daily, increased, if necessary, 0 or 200 mg. Maintenance dosage be lower, 50 to 150 mg. daily, if ible.

Geriatric and Adolescent Dosage: Initially, 30 or 40 mg. daily, which may be increased according to response and tolerance. It is usually unnecessary to exceed 100 mg. daily.
A lag in therapeutic response, lasting from a few days to a few weeks, should be expected. When dosage recommendations are already being followed, increasing the dosage does not normally shorten this latency period and may increase the incidence of adverse reactions.
Availability: Round tablets of 25 and 50 mg.; triangular tablets of 10 mg. for geriatric and adolescent use; and ampuls, each containing 25 mg. in 2 cc. for I.M. administration.
(B)R-46-850-C

For complete details, please refer to the full Prescribing Information.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

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physicians and health professional personnel to meet the health needs of our state.

Most of you are aware that in 1965 an effort was made in the Legislature to authorize an additional medical college under auspices of the University of South Alabama. Because of the tremendous expense involved in such an undertaking and because of the deficiencies in certain areas in the instructional program at the University Medical Center in Birmingham, the Legislature authorized instead a comprehensive medical education facilities study in the state. The consulting firm of Booz, Allen & Hamilton of Chicago was retained to make this survey, and its report has been submitted to interested parties.

The firm's report calls for extensive improvement of programs and facilities at the University Medical College in Birmingham including the upgrading of the program to admit 125 entering students a year by 1971 instead of the present 80 students. It also calls for the Medical College to establish a two year basic medical science school for first and second year medical students on the main campus in Tuscaloosa. It further recommends that the University establish a formal relationship with Mobile General Hospital in creating and operating a clinical program in Mobile for third and fourth year medical students to become the nucleus for a much needed second state medical school at the University of South Alabama. Following the implementation of a residency-internship program in North Alabama the University would help establish a third medical school in conjunction with the University's Huntsville campus.

This is a most ambitious program, but in the concluding words of the report "with a high degree of joint planning among state officials, the University of Alabama, the University of South Alabama, and other institutions, the challenge of medical manpower, common to all, can be met successfully."

You will be interested to know that since the filing of the report much work has been directed toward the necessary planning to meet the suggested time table for the development of the recommendations. We can recognize that large sums of money will be necessary for capital outlay and for operating expenses in connection with these recommendations; yet I would remind you that we are talking about health facilities and personnel to provide hope and treatment for the ill, infirm and handicapped people of Alabama. The realization of the recommendations of the report will provide medical manpower to meet our needs and, perhaps most importantly, will make available a program of continuing education to the practicing physicians of Alabama where the latest developments of techniques and treatments can be utilized in communities throughout our state.

I continue to hear and read of comments reflecting on various opinions concerning medical education in our state—it is obvious that most of these comments are based on the understandable desire of the commentator to see medical education facilities developed in his own region of the state. Gentlemen, this attitude will not help us in realizing our medical education goals. The implementation of the planned p r o g r a m which I have discussed with you today will provide medical education facilities in North Alabama, Mobile, Tuscaloosa and Birmingham as well as continuing medical education programs in many, many other areas of our state. Let's join our resources and talents toward these goals and forever turn away from provincialism.

Last fall I had the privilege of touring the facilities of the Medical Center. What a joy it was to see the great progress and advances which have been made here—but how vividly it was brought to my mind the work which remains to be done.

I saw the dializing unit and learned what was being done for people who once had no hope, and I learned of the limited facilities

available, the relatively small number of people who could be offered this treatment, and I thought of the numbers of Alabama citizens who had to be turned away under sentence of death or severe disability because of the lack of this equipment—how inconsistent we are when we spend millions to protect a life in a mine disaster, and properly so, but fail to spend $10,000.00 per year for a patient to receive this treatment which literally offers life and hope to many Alabamians.

You probably heard last week of the announcement of the urban renewal project which will make possible the expansion of the physical plant at the Medical Center—you also are aware of the plans of the Jefferson County Commission to construct a mercy hospital for the care and treatment of indigent patients—you may have heard of the plans for a diabetic hospital in the Medical Center, a burn institute, numerous research facilities—just last week I read with interest of a comment made by Governor Wallace reflecting her concern over the very real need which we have in Alabama for a hospital or tumor institute offering intensive care and treatment to persons suffering with cancer—in the expansion of the physical facilities of the Medical Center I propose that we include a tumor institute similar to many famous such institutions across this country, designed for the treatment of cancer and where any citizen of Alabama, on referral of his physician, may receive the latest in care and attention. We should be determined that Alabama citizens have the advantage of the finest health care available in this nation.

You who are here today have dedicated your lives to relieving the suffering and extending the life expectancy of your fellow man. To do what needs to be done will require great sums of money, and there are many who will say we can't afford it, but for every person in Alabama who has experienced personally or in his own family the dread ravages of disease and infirmity, we will hear the response "we can't afford not to do it."

We have already tarried too long.

Birmingham Academy Names MPA Dates

Dates for the 1968 Medical Progress Assembly, held each year, are September 22, 23 and 24. Sponsor of the annual symposium, the program of which is designed to explore new advances which are applicable to private clinical practice, is the Birmingham Academy of Medicine.

This year's Assembly follows immediately on the heels of two major football games at Birmingham's Legion Field—the University of Alabama and V. P. I. Saturday, September 21, and the Boston Patriots and New York Jets the following day.

Sunday evening banquet speaker will be Al Capp, creator of "L'il Abner" and NBC commentator. Monday evening's social function is expected to be highlighted by Minnie Pearl.

Although Medical Progress Assembly scientific sessions don't begin until Monday morning, September 23, the Alabama Chapter of the American Diabetes Association has scheduled its annual fall scientific meeting Sunday afternoon. All meetings are scheduled for Birmingham's Parliament House Hotel.

The Assembly will be accepted for 14 hours of Category I A.A.G.P. Credit.

PHYSICIAN PLACEMENT SERVICE IN ALABAMA

The Physician Placement Service of the Medical Association of the State of Alabama is designed to assist both physicians and communities. MASA members having knowledge of practice opportunities or wishing to relocate their own practices are urged to communicate with the Placement Service. For further information: write Mr. Emmett Wyatt, Executive Assistant, Medical Association of the State of Alabama, 19 South Jackson Street, Montgomery, Alabama 36104, or Telephone 263-6441.

Locations Wanted

Anesthesiology—

Age 37; University of Pittsburgh, 1957; seeking group or associate practice. Available October 1968. LW-334

General Practice—

Age 27; Louisiana State University 1967; seeking group or associate practice. Available August 1968. LW-335

Age 38; University of Oklahoma, 1955; seeking associate, institutional or industrial practice; in town of 10,000 plus population; interest in surgery. LW-336

Age 28; University of Tennessee, 1965; available November 1968. LW-337

Age 28; Medical College of Alabama 1966; seeking practice in town of less than 14,000 population to fulfill scholarship requirements. Available 1968. LW-338

Age 52; University of Chicago 1950; seeking group, industrial, institutional or student health position. LW-339

Age 56; Georgetown University 1938; seeking solo, group or associate practice, with general surgery. Available July 1968. LW-340

Internal Medicine—

Age 32; University of Wisconsin 1962; Board eligible; seeking associate practice. Available July 1968. LW-341

Age 34; Hahnemann Medical College 1959; Board eligible, National Board; seeking solo, group, or associate practice. Available immediately. LW-342

Age 34; University of Tennessee, 1958; American Board Certified, seeking group, industrial, or institutional practice. Available Spring 1968. LW-343

Neurology—

Age 31; Harvard 1962; Board eligible; National Board; seeking solo, group or associate practice. Available July 1969. LW-344

Age 30; Medical College of Alabama 1962; Board eligible; National Board; seeking solo, group, associate or institutional practice. Available January 1969. LW-345

Obstetrics-Gynecology—

Age 35; Vanderbilt University 1950; Board eligible; Available July 1968. LW-346

Age 37; University of Virginia 1959; Board certified; seeking group or associate practice. Available September 1968. LW-347

Age 34; University of Missouri 1959; Board certified; seeking group, industrial, associate or institutional practice. Available July 1968. LW-348

Age 36; Medical College of Alabama 1957; Board eligible; seeking group or associate practice. Available immediately. LW-348-A

Psychiatry—

Age 38; University of Florida 1961; Board certified; seeking group, associate or institutional practice. Available mid-1968. LW-349

Radiology—

Age 31; S. U. N. Y. College of Medicine, 1961; Board eligible; seeking solo, group, or associate practice. LW-350

Age 41; Cornell Univ. Medical School, 1953; Board certified; seeking group, or associate practice. Available immediately. LW-351

Age 51; Univ. of Texas Med. Branch, 1942; Board certified; seeking solo, group, or associate practice. LW-352

Surgery—

Age 33; University of Missouri, 1961; seeking group or associate practice. Available January 1969. LW-353

Age 38; Emory University, 1956; Board eligible; seeking group, associate, or institutional practice. Available July 1968. LW-354

Age 37; Faculty of Medicine, Manitoba, 1957; Board certified; seeking associate or institutional practice. Available July 1968. LW-355

Age 34; Board eligible; University of Santo Tomas, 1961; seeking group or associate practice. Available July 1968. LW-356

Age 35; Board eligible; Univ. of Santo Tomas, 1956; seeking solo, group, industrial or associate or institutional practice with general practice. Available immediately. LW-357

Student Health—

Age 43; Tulane 1949; Available immediately. LW-358

Age 41; Yale University 1951; National Board. LW-359

Physicians Wanted

General Practitioners—

For town in South Alabama with 20,000 trade area, within 40 miles of Gulf beaches and large city. Excellent hunting and fishing. Numerous industries offering stable employment for area. Furnished office available rent free. Hospital presently engaged in complete remodeling and expansion. PW-212

Unusual opportunity for two general practitioners with military obligations satisfied at a modern fifty bed facility located 15 minutes drive from largest metropolitan center in north-central Alabama. Construction of a new two-story office building is scheduled to begin soon. PW-213

Opportunity in rapidly expanding community of 10,000-12,000 population adjacent to metropolitan center in north Alabama. Office space free for six months and equipment available. Staff privileges at nearby hospitals. PW-214

For town of 3,600 population in trade area of 5,000-7,000 within 100 miles of two large cities and the Gulf Coast. 50-bed hospital located in the town. Office space available. Agricultural and expanding industrial area. Several churches and two schools. Recreational activities in the town as well as nearby—golf course, hunting and fishing. PW-215

For town of approximately 1,000 population in North-central Alabama in trade area of 12,000 population. 100-bed hospital in adjoining city. PW-216

For town of 12,500 population in trade area of 50,000 located in South Alabama. Nearest large city with population of 145,000 is 80 miles. One of the physicians died recently. Two hospitals with 140 beds. Numerous small industries; several churches and schools. Recreational activities include water sports and golf course. PW-217

For town of approximately 1,000 population in population center of 10,000 located in Southwest Alabama within 90 miles of the Gulf coast. City owned clinic is offered rent free and fully equipped. Hospitals are located in two nearby towns within 25 miles. This is principally an agricultural region, but there are military installations nearby. Numerous civic clubs, community concert series, and a country club offer recreational activities. PW-218

For town with 1,000 population in trade area of 5,000 Southeast Alabama. Nearest large city with population of 50,000 is 55 miles. New clinic available rent free. No physicians in the town. Hospitals in surrounding town within 30 miles. Several churches and schools. PW-219

Opportunity in city of 5,000 population located in Northeast Alabama in trade area of approximately 10,000 population. Office space available. One physician died recently. Hospital and nursing home in the city. PW-220

For town of 1,000 plus population in west-central Alabama in trade area of 20,000. Clinic available. Nearest city of approximately 70,000 population is located a distance of 17 miles. Farming, cattle, timber, and manufacturing plants are principal resources of the area. Churches, schools, and recreational advantages. PW-221

For solo practice in town of approximately 17,000 population located in east central Alabama. 48-bed general hospital. Arrangements available for office space. Excellent recreational advantages which include hunting, fishing and water sports. City owned airport. Numerous civic clubs. Excellent schools and churches. Expanding industrial and agricultural area. PW-222

Opportunity for one or more doctors in rapidly expanding eastern suburb of Birmingham. Attractive brick building consisting of 10 rooms and adjacent parking facilities. PW-223

Opportunity for general practitioner to join a five-man group, practicing as a partnership. Each man in the group is either specialized or semi-specialized. The practice is physically located within a 70-bed hospital. Willing to pay qualified person $36,000 for the first year, with possible partnership status in one year. Would consider a physician for locum tenens for three to six months at $2,000 per month. PW-224

Opportunity in centrally located town in North Alabama in trade area of 10,000-15,000 population. The only doctor is retiring. Housing and office space readily available. Churches and schools. Recreational advantages of nearby lakes. PW-225

Surgeon—

Opportunity for a Board eligible or Certified surgeon to practice in city of over 78,000 population in north Alabama. Equipment available. PW-226

Special Openings

Specialist in the following fields: Internal Medicine, Pediatrics, Obstetrics-Gynecology and General Practitioners. 58 bed fully accredited general hospital with 91 bed addition to be completed in July 1968. Modern new office space available. PW-227

Medical Superintendent of 225 bed tuberculosis sanatorium with a building program in Birmingham. Salary and job description negotiable. Must be able to obtain Alabama license. PW-228

Physician interested in Internal Medicine and Chest Diseases to provide general medical services in 184 bed Tuberculosis Hospital in North Alabama. References and experience data required in advance. U. S. citizens and fully licensed physicians given first choice. Others will be considered upon request. Salary open. PW-229

Jefferson County Burn Injury Project

By Joe R. Everett, M. A.

Each year in the United States nearly two million persons suffer burns which either require medical care or cause at least one full day of restricted activity. A huge number of these occur in and around the home. Burn injuries are also the cause of 8,000-10,000 deaths annually.

Approximately two-and-one-half years ago the Jefferson County Health Department (Alabama), working under a grant from the U. S. Public Health Service, initiated a Burn Injury Control Project with the following objectives:

1. To identify those agents which are primarily responsible for causing burns in the home
2. To design a community-wide educational program aimed at the reduction of burn injuries through prevention, and
3. To implement the educational program.

Information for the study was obtained from the records of local hospitals spanning a five-year period (January 1, 1961-December 31, 1965).

The causes of the burns were correlated with the age of the victim; sex; race; the year, month and time of day the burn occurred; the parts of the body burned; the degree of the burn; number of days hospitalized; type of treatment and indirect causes.

A wide variety of causes were studied including all types of stoves and heaters, flammable liquids, open fires, scalding materials, electrical appliances, and explosions.

A few interesting findings from the study include:

The age most affected by all types of burns are children between the ages of one and five. Forty-one per cent occurred in this age group.

Burns caused by scalding from hot water, hot coffee and hot grease are the *most frequent types* of burns which occur in the home.

The *most serious* burns are those which occur when the victim's clothing catches fire. This type burn usually results in a higher degree of burn, covers a greater percentage of body area, and requires a long period of hospitalization and more intensive care.

The time of day when most burns occur is significant. Evening hours between 5:00-8:00 are the times of day when burns are most frequent.

The arms, hands, and legs are the parts of the body most frequently burned from all causes.

Adults are more likely to be burned from explosions.

Burns from careless use or storage of gasoline more often involves the male than the female and are more frequent in white than non-white.

Mr. Everett is Senior Health Educator, Jefferson County Department of Health.

One hundred per cent of burns from electric heating pads occurred to adult, white females.

Some burns are seasonal. This is especially true of those caused by heating appliances which occur primarily during the late fall and winter months. Scald burns are not seasonal. They tend to be a problem year round. Burns from trash fires occur in the fall when people burn leaves and in the spring months when spring house cleaning calls for burning of discarded items.

Seventy-two per cent of cigarette burns were to the eyes. A large percentage of these were to children under five years of age. Normally a cigarette burn is not serious enough to seek medical attention, but when it occurs to the eyes there is a greater possibility of serious and lasting effects.

The majority of burns are self-inflicted.

Few exotic, spectacular or earth-shaking causes of burns were revealed by the study. Most were the result of carelessness and most could have easily been prevented.

BUREAU OF PREVENTABLE DISEASES

W. H. Y. Smith, M. D., Director

Current Morbidity Statistics
1968

	April	May	*E. E. May
Tuberculosis	117	94	134
Syphilis	85	67	135
Gonorrhea	340	558	327
Chancroid	0	2	1
Typhoid fever	0	0	1
Undulant fever	0	0	0
Amebic dysentery	2	3	3
Scarlet fever & strep. throat	409	364	77
Diphtheria	1	0	0
Whooping cough	12	1	6
Meningitis	6	5	6
Tularemia	0	0	0
Tetanus	0	0	1
Poliomyelitis	0	0	0
Encephalitis	0	0	0
Smallpox	0	0	0
Measles	10	12	305
Chickenpox	119	20	160
Mumps	46	49	77
Infectious hepatitis	18	22	46
Typhus fever	0	0	0
Malaria	0	1	0
Cancer	628	947	728
Pellagra	0	0	0
Rheumatic fever	12	18	17
Rheumatic heart	19	18	30
Influenza	145	36	87
Pneumonia	299	469	243
Rabies—Human cases	0	0	0
Pos. animal heads	3	4	0

As reported by physicians and including deaths not reported as cases.

*E. E.—The estimated expectancy represents the median incidence of the past nine years.

BUREAU OF VITAL STATISTICS

PROVISIONAL BIRTH AND DEATH STATISTICS AND COMPARATIVE DATA

Ralph W. Roberts, M. S., Director

March 1968

Live Births / Deaths / Causes of Death	Number Registered During March 1968			Rates* (Annual Basis)		
	Total	White	Non-White	1968	1967	1966
Live Births	4,857	3,162	1,695	15.9	16.7	18.4
Deaths	2,871	1,909	962	9.4	8.5	9.4
Fetal Deaths	121	49	72	24.3	19.4	17.4
Infant Deaths—						
under one month	96	51	45	19.8	16.7	14.2
under one year	154	69	85	31.7	26.7	28.2
Maternal Deaths	3	1	2	6.0	7.6	10.7
Causes of Death						
Tuberculosis, 001-019	26	10	16	8.5	7.9	8.0
Syphilis, 020-029	4	2	2	1.3	0.7	1.7
Dysentery, 045-048						0.3
Diphtheria, 055						
Whooping cough, 056						
Meningococcal infections, 057	3	2	1	1.0	1.3	0.3
Poliomyelitis, 080, 081						
Measles, 085						
Malignant neoplasms, 140-205	386	271	115	126.4	121.0	124.0
Diabctes mellitus, 260	52	27	25	17.0	17.8	18.4
Pellagra, 281					0.3	
Vascular lesions of central nervous system, 330-334	420	242	178	137.6	108.7	125.0
Rheumatic fever, 400-402						
Diseases of the heart, 410-443	960	730	230	314.5	298.7	305.3
Hypertension with heart disease, 440-443	103	53	50	33.7	31.7	44.1
Diseases of the arteries, 450-456	67	46	21	21.9	17.8	25.1
Influenza, 480-483	11	7	4	3.6	0.7	7.0
Pneumonia, all forms, 490-493	81	50	31	26.5	23.8	32.8
Bronchitis, 500-502	10	8	2	3.3	2.0	4.0
Appendicitis, 550-553	3	1	2	1.0	0.3	0.7
Intestinal obstruction and hernia, 560, 561, 570	14	10	4	4.6	3.0	3.0
Gastro-enteritis and colitis, under 2, 571.0, 764	9	2	7	2.9	1.6	2.0
Cirrhosis of liver, 581	32	21	11	10.5	6.9	6.4
Diseases of pregnancy and childbirth, 640-689	3	1	2	6.0	7.6	10.7
Congenital malformations, 750-759	27	23	4	5.6	5.4	6.4
Immaturity at birth, 774-776	30	13	17	6.2	5.8	4.7
Accidents, total, 800-962	199	144	55	65.2	61.5	73.6
Motor vehicle accidents, 810-835, 960	95	75	20	31.1	32.4	35.8
All other defined causes	362	231	131	118.3	115.7	130.1
Ill-defined and unknown causes, 780-793, 795	172	68	104	56.3	43.0	51.2

*Rates: Birth and death—per 1,000 population
Infant deaths—per 1,000 live births
Fetal deaths—per 1,000 deliveries
Maternal deaths—per 10,000 deliveries
Deaths from specified causes—per 100,000 population

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BUREAU OF PREVENTABLE DISEASES

W. H. Y. Smith, M. D., Director

Current Morbidity Statistics

	1968		
	March	April	*E. E. April
Tuberculosis	156	117	119
Syphilis	105	85	142
Gonorrhea	324	340	294
Chancroid	0	0	2
Typhoid fever	0	0	1
Undulant fever	0	0	0
Amebic dysentery	4	2	5
Scarlet fever & strep. throat	721	409	151
Diphtheria	0	1	0
Whooping cough	14	12	8
Meningitis	17	6	7
Tularemia	0	0	0
Tetanus	0	0	1
Poliomyelitis	0	0	0
Encephalitis	0	0	0
Smallpox	0	0	0
Measles	25	10	497
Chickenpox	105	119	163
Mumps	96	46	92
Infectious hepatitis	39	18	43
Typhus fever	0	0	0
Malaria	0	0	0
Cancer	712	628	662
Pellagra	0	0	0
Rheumatic fever	10	12	18
Rheumatic heart	23	19	29
Influenza	384	145	376
Pneumonia	348	299	334
Rabies—Human cases	0	0	0
Pos. animal heads	4	3	0

As reported by physicians and including deaths not reported as cases.

*E. E.—The estimated expectancy represents the median incidence of the past nine years.

BUREAU OF LABORATORIES

Thomas S. Hosty, Ph. D., Director

May 1968

Examination of Intestinal Parasites	2,702
Examination of Malaria	2
Examination for Salmonella & Shigella (blood-feces-urine-food)	244
Examination for tubercle bacilli	5,239
Examinations for gonococci	2,492
Serological tests for Syphilis	33,769
FTA & Check Specimens	122
Darkfield	6
Brucella	0
General Bacteriology (cultures for isolation and confirmation)	28
Staphylococcus (cultures for isolation and confirmation)	9
Examinations for diphtheria (cultures for isolation and confirmation)	10
Streptococci examinations	2,476
Mycology	29
Agglutinations	13
Vincent's infection	6
Complement fixation tests	173
Tests for phenylketonuria (PKU)	6,484
Cytology	1,990
Water examinations	3,306
Milk and Dairy products examinations	5,768
Sea food examinations	246
Examination for Negri bodies (smears & animal inoculations)	372
Virology	12
Rh factor bloods	767
Miscellaneous	1,012
Total	67,277

10th Conference Slated On Sports Medicine

The Tenth National Conference on the Medical Aspects of Sports, sponsored by the American Medical Association under the auspices of its Committee on the Medical Aspects of Sports, will be held in Miami Beach, Florida, at the Hotel Deauville on December 1, 1968. The Conference is held annually in conjunction with and on the first day of the Clinical Convention of the American Medical Association.

As was true of the previous nine Conferences, the Tenth will cover a wide range of subjects of interest to those serving school and college athletic programs. Included will be forums on the management of knee injuries, back problems, and problems related to vision in sports. Other sessions will be devoted to a series of clinical concerns in sports warranting increased attention (eg, cauliflower ear, pulled muscles, facial injuries, and communicable disease). One discussion session will be devoted to the controversial issues affecting participation of young athletes, another to health and safety considerations in the conduct of aquatic activities.

The featured luncheon speaker will be Payton Jordan, Head Coach of the 1968 U. S. Olympic Track and Field Team, who will discuss "The Olympics in Retrospect."

The Conference is open to key nonmedical athletic personnel as well as interested physicians. Those who would like to receive further information concerning the Conference should address the Committee on the Medical Aspects of Sports, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

Why Collegiate Programs for Nurses?

By

Anne Kibrick, R. N., Ed. D.

Dean, Boston University School of Nursing

The subject of how nurses should be educated has been a matter of controversy for some time. It was brought into sharp focus by the recent position paper of the American Nurses' Association (ANA). This organization, taking cognizance of trends in this country, unequivocally stated in 1965 that the predominant existing programs for educating nurses were no longer adequate for preparing the professional nurse practitioner needed by today's society. The major points of the position paper were as follows: education for all who are licensed to practice nursing should take place in institutions of higher education; minimum preparation for beginning professional nursing practice should be baccalaureate-degree education in nursing; and minimum preparation for beginning technical nursing practice, at present, should be associate-degree education in nursing.

The report was a real blow to hospital-operated diploma programs for nursing education, since it implied that they were outside the framework for acceptable nurse preparation. This position, however, does not reflect the opinions of nurses alone. In 1918 a conference of men and women active in the field of public health, general education and higher education studied nursing in this country and, without a dissenting voice, agreed that the preparation of the professional nurse belonged squarely within institutions of higher learning. The Yale University School of Nursing was established as a result of this study. In 1926 a committee of physicians, nurses and representatives of the public and the field of higher education recommended that education for nursing, like education for other professional service occupations (such as medicine and teaching) should be a public responsibility and that the cost of education should come from private and public funds, not from hospitals. The conclusion that professional nurses should be prepared in institutions of higher learning was reconfirmed by additional studies in 1941 and in 1948. Both these studies were directed by non-nurses. It is significant that this thesis was reiterated in 1967 by the National Advisory Commission on Health Manpower. One could continue quoting other similar reports, but it would be repeating the fact that, over the past half century, informed educators, interested citizens and the physicians who have participated in these studies have agreed that education for nursing practice should be the responsibility of colleges and universities if the health objectives of the nation are to be met.

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When nursing schools were first organized in this country, less than 100 years ago, the nurses' functions were clearly outlined, and nurses filled a well defined role in the care of patients. However, the past 30 years have brought about changes in the nurses' functions, both in the hospital and in the community. Basic to present trends in nursing education is the fact that the nature of the work for which the professional nurse is preparing is significantly different from what it was when the hospital-school pattern of education was established.

The professional nurse prepared in the baccalaureate program is a liberally educated person, as well as a competent practitioner. She is expected to use all her knowledge and skills in promotion of health and assistance with healing. She co-ordinates and synchronizes medical and other professional and technical services that affect the patient, and collaborates with physicians and other health workers in the care of patients. She not only

gives skilled nursing care but can supervise, teach and direct all others who participate in such care. She can identify nursing problems, establish priorities and evaluate the results of nursing-care plans. She is prepared to share the responsibility for community health programs, and continually evaluates nursing practice itself as she works to improve service to patients and to the community. In the absence of the physician, the professional nurse is expected to make independent sound judgments in the care of patients and families. She must know why, and under what conditions, to initiate nursing action. The professional nurse is prepared as a generalist at the baccalaureate level and as a specialist at the graduate level. Graduate programs prepare nurses for specialization in pediatric, maternity, public-health and medical-surgical nursing, as well as in teaching, supervision, administration and research.

The technical nurse, on the other hand, is primarily a skilled practitioner with a circumscribed set of activities that are carried out in relatively controlled settings, such as hospitals or doctors' offices. She uses clearly defined and comparatively simple scientific principles in carrying out her nursing functions under the guidance of professional nurses or physicians. The technical nurse does not have the background to make judgments demanding knowledge of the social and biologic sciences, but she does make decisions within a relatively small range of choices that are generally clearly outlined.

With the continuing trend toward specialization in medical care, the professional nurse needs the assistance of the technical nurse to carry out all the measures and routines necessary for the care of the patient. The ratio of technician to professional will become larger as knowledge increases, and the technical nurse will retain an essential part in the nursing care of patients.

(Continued on Page 82)



Although there are differences in the educational patterns and educational goals of programs preparing professional and technical practitioners, both kinds of programs are necessary for the efficient use of nursing personnel and for safe and effective nursing care. Each type of program is a career in itself, and excellence of practice within the framework of their responsibility should be the goal. Nurses in a baccalaureate program acquire breadth of learning and depth of understanding as they become members of a learned profession. Hospitals and junior colleges, on the other hand, train their students to become members of a skilled occupation.

Often one hears the complaint that college nursing programs are responsible, in good part for the insufficient numbers of students, and that the ANA position paper hastened the decline in nursing-school enrollments. Actually, the decline in hospital programs had begun in 1961, when there was a peak enrollment of 96,606, and the position paper did not appear until December, 1965. In fact, a recent report by an economist states that collegiate schools have helped maintain the supply of nurses rather than curtailed it. Because of the trend of girls to enter college, the fact that college programs increased by threefold since 1946 has offset, rather than caused, the decrease in hospital-school enrollment. The reality is that diploma-school education has become less attractive. For many years hospital programs, in general, have not met their quota of students. The hospital-school nursing program, which had its beginning in noble aspirations, is no longer adequate to meet the challenge of the needs of today's society for health services.

Criticism is leveled by some against the collegiate nurse, indicating that she does not have enough experience with patients, that her education is too theoretical, without sufficient attention to practice, that she is too educated to be interested in nursing patients, that she is inadequately prepared for work in a hospital and that she cannot function efficiently on the wards on the day of graduation. These criticisms are not valid.

All college programs provide experience with patients. Students work with patients when they have acquired the academic background from which to develop sound nursing practice. The students' experience is guided, and when they have become competent in one area, they move on to another requiring greater skills and more knowledge. Baccalaureate students generally receive training in several hospitals, as well as in community agencies. They are not as familiar with any one hospital as the graduates of diploma programs, who spend most of their three-year training period in one institution. To expect them to assume responsibilities on the day of graduation, in an institution with whose routines and policies they may not be familiar, is unrealistic. A period of orientation for any new employee is common practice, and it does not take an intelligent nurse very long to familiarize herself with the routine practices of an institution.

In general, increased education in a subject matter results in greater interest in the subject. It is difficult to believe, as is sometimes stated, that increased education in nursing results in less interested nurses. Increased education results in nurses who see their responsibilities in the broad areas of man's well-being.

Upon graduation from the baccalaureate program proficiency with specific technics may be lacking because this program does not emphasize technical skills. It is significant that this is also the current trend in medical education. One does not have to make beds, give injections or follow daily routine for several years to acquire these skills. There is no question that, in general, diploma-school students are more technically skilled upon graduation than baccalaureate students. Emphasis in collegiate programs is on the ability to make critical judgments, using a background of knowledge as a basis for action. There are many daily routines of a technical nature that have to be done in hospitals, and these can be performed by competent nurse technicians.

The programs that hold the greatest promise for increasing the supply of nurse technicians are those being established in the two-year junior community colleges. Five experimental programs were begun in 1952 to determine if students could be prepared in less than three years in an educational institution for functions commonly associated with the registered nurse. These programs were integral parts of educational institutions and led to an Associate in Arts, or Associate in Science, degree in nursing (Associate Degree in Nursing, or ADN). The curriculum maintained a balance of both general and professional education, with clinical practice. The evaluation of the program was based on State Board results and employer's and student's evaluations. The results were so successful that, today, there are 281 such programs and new ones are opening daily. The enrollment in these programs has increased from approximately 1,000 students in 1956 to 15,500 in 1966.

There are many good reasons why this program was a success from the beginning and why it will continue to remain popular. The ADN program requires two years of preparation before licensing examinations; the hospital program requires three years. In general, women whose primary goal is marriage, tend to select occupations requiring shorter periods of preparation. Because licensing examinations can be taken a year earlier, the nurse's earning power begins a year earlier. Although a few of the ADN programs are in private institutions, the greater majority by far are in community-supported junior colleges; consequently, the tuition is low, $200 per year, or $400 for the total program. Few people realize that tuition in hospital programs generally is considerably greater, ranging from approximately $1,000 to $3,000 for the total program. Students are attracted by the opportunities for a broader social life in the college setting. In the junior college the student earns an Associate Degree, whereas in the hospital she earns no degree.

(Continued on Page 86)



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Dextro-amphetamine sulfate: Excessive use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised, especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on the drug. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of preexisting symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dosage and avoid operation of motor vehicles, machinery or other activity requiring alertness. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.
Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness. Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia; the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

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(Continued from Page 83)

If the ADN student chooses to go on for a baccalaureate degree, she generally receives college credit toward the degree for her liberal-arts courses, and many take equivalency examinations for credit in nursing courses. The diploma school graduate is generally not granted any college credit on the basis of her program. In some baccalaureate programs, however, diploma students are permitted to take equivalency examinations based on their knowledge and ability in nursing practice. To date, very few such candidates have successfully passed these examinations.

There are several reasons why college credit is not granted for hospital nursing programs. The faculty in diploma programs generally do not meet the criteria for faculty appointment to university programs, where the minimum educational requirement is a Master's degree. In diploma programs 19 per cent of faculty hold a Master's degree: 56 per cent hold only a Baccalaureate degree, and 25 per cent hold only a diploma. Students admitted to diploma programs would not necessarily meet the admission requirements of collegiate programs. Nursing practice in collegiate programs builds on, and integrates, the liberal arts into the nursing curriculum; to give college credit for nursing courses taken apart from the liberal arts, or before acquiring a broad base in the arts and sciences, would contradict the entire philosophy and practice of collegiate education. Students who enter diploma programs with aspirations for going on to college should be aware of the fact that they may have to begin as freshmen in the nursing program.

There are comparable examples in the field of medicine; for instance, medical schools do not grant credit to nurses who, after completing their program, might choose to elect a medical career, nor do specialty boards give credit for medical practice obtained before specialty training. Professional nursing and technical nursing are two different careers: one type of program does not build on another; each program is distinct. The knowledge acquired and the responsibilities and intellectual demands of both groups are different. The application of knowledge to effective practice and judgment making differentiates the groups.

The advantages of the ADN programs, listed above, would appear to assure that they will eventually replace the hospital diploma programs as the source of technical nurses. The students who would not qualify for an ADN or baccalaureate program should be trained in short, intensive, preservice programs in vocational educational institutions.

In contemporary society, increasingly large numbers of students are moving from high school on to college, and this phenomenon is reflected in both the associate and the baccalaureate programs. This increase is due not only to a rising population but also to rapidly increasing percentages of students going on for higher education. In 1954, 29 per cent of the 18-year olds went to college; in 1964, this figure increased to 37 per cent, and it is predicted that, in 1974, 46 per cent of the 18-year olds will be going on to college. This movement is supported by the Federal Government, which is increasingly financing higher education.

In the light of these trends, one can see why diploma programs have little appeal as a vehicle for nurse recruitment. Last year, 3,000 fewer students enrolled in diploma programs than in the previous year, and enrollments have been declining yearly. In the same period, enrollments increased by approximately 4,000 in ADN programs and about 2,300 in baccalaureate programs. Enrollments in ADN programs have been rising by 1,000 or more yearly since 1961. In October, 1967, the number of diploma schools had decreased to 767. However, the number of ADN programs had increased to 281, and the baccalaureate programs to 221. This does not reflect the fact that, in 1966-1967, 10 baccalaureate programs and 60 ADN programs were too new to have had admissions, and 20

baccalaureate and 100 ADN programs were too recent to have graduated any students.

Good hospital nursing programs are expensive to operate. Hospitals admit that the cost of educating a nursing student exceeds the income derived from tuition and service. A study of 126 diploma programs showed that it cost the hospital $2,600 a year to educate a nursing student and that the income to the hospital, considering tuition, fees and service, was $1,000 per year. With rising hospital costs, the question of whether nursing education should be underwritten by patients, or should be a part of the tax base, as are many other educational programs, becomes a critical one. Over one third of the present diploma programs graduate 20 or fewer students. Schools that enroll 70 or fewer students are the most expensive to operate. The continuation of these programs cannot be justified in the light of their high cost and the shortage of faculty. Meanwhile, many collegiate nursing programs, the most efficient means of educating large numbers of students, are required to limit their enrollment because of a lack of clinical resources, as hospitals use their resources for education of their own students.

Nursing education programs and nursing service institutions both have as their ultimate goal the improvement of nursing services to people. The primary purposes of service institutions and educational institutions, however, should not become confused. The major responsibility of educational institutions is the education of the student. The major responsibility of the hospital is the care of the sick; consequently, in the diploma programs the education of the student is often subordinated to the service needs of the hospital.

The transition of nursing programs from hospitals to educational institutions would benefit hospitals as well as nursing education. Hospitals have a vital role in the edu-

(Continued on Page 88)

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cation of nurses through their resources and clinical facilities. Because an association with a medical school improves hospital medical practice, hospitals rightfully take pride in their affiliation with a medical school. Hospitals could derive comparable benefits in being connected with collegiate nursing programs. If collegiate nursing schools were to utilize their specialists in assuming the responsibility for nursing care in hospitals this would upgrade the quality of care and thus improve the clinical teaching to students. In addition, faculty members in schools of nursing could combine research with practice and teaching, thus benefiting both nursing care and nursing education. Hospitals must work with collegiate schools of nursing and engage in a dialogue that will help determine their future relation.

Hospitals are as essential for sound nursing education as they are for medical education. To become effective practitioners, students must be significantly involved in meaningful responsibility for patient care. Hospitals should not, however, administer the nursing education program any more than they administer the medical education program. Both medicine and nursing need a sound theoretical background for intelligent and understanding work with patients. For most effective learning, the hospital experience of the nursing student should be under the supervision of the medical-school faculty. just as hospital medical education is under the supervision of the medical-school faculty.

Hospital programs prepare nurses for work primarily in hospitals. A major argument advanced for retaining hospital schools is that approximately 60 per cent of the graduates remain on to work in the hospital. However, many of these remain for only about one year. The difficulty of hospitals in obtaining nursing personnel, admittedly a serious problem, is insufficient justification for hospitals to operate nursing programs. This argument also denies the needs of many other segments of the population where nursing services are needed. One of every 10 nursing homes does not have a single registered nurse in its employ. Many others employ only one registered nurse, who is generally used in an administrative capacity rather than in setting a standard for excellent nursing care through demonstration and practice. Diploma students do not receive experience in public-health agencies or other comprehensive community health agencies, and are unprepared for service in these units. Although hospital programs focus on the care of the patient in the hospital, there are a host of other health needs in society that nursing must accommodate.

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Though originally developed for the benefit of key men in the AMA organization, demand for it became so great that it was decided to make it available on a subscription basis. Twenty-four issues—plus a 22-page case Index twice a year and occasional texts of the most important medicolegal decisions —may be obtained for the nominal sum of $6.00 for a one-year subscription or $9.00 for a two-year subscription, provided you reside in the U. S., Possessions, Canada or Mexico. Medical Students, interns and residents in these areas are eligible for subscriptions at a 50 per cent reduction. In all other countries, the prices are $12.00 and $18.00 respectively.

Orders, which should include the remittance, should be directed to the American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

New Blue Shield Program Offered

By William H. Mandy

Vice President—Sales, Blue Cross-Blue Shield

Like medicine, health coverage evolves by building upon the technology and experience that have served its purposes in the past. New developments seldom appear overnight, and when they do they tend to be suspect until a testing period confirms or disproves their value. Programs to pay the usual and customary charges of physicians are emerging from such a period.

Blue Cross-Blue Shield of Alabama is now offering a new Blue Shield program that is designed to provide more predictability of costs. This innovation in health coverage is called the usual and customary program.

However, the program is available at present only to those groups of 50 employees or more.

The usual and customary program can be purchased on a 70 per cent, 80 per cent, 90 per cent, or 100 per cent basis. This means that Blue Cross-Blue Shield will cover 70 per cent of the full payment, 80 per cent of the full payment, etc.

In determining what constitutes the usual and customary fee, Blue Shield will take into consideration:

The usual fee which the individual physician most frequently charges to the majority of his patients for a similar service or medical procedure;

The fees which fall within the customary range of fees charged in a locality by most physicians of similar training and experience for the performance of a similar service or medical procedure;

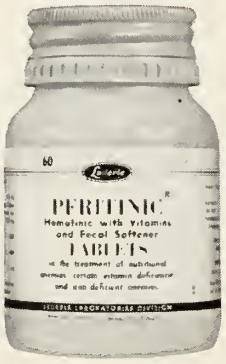
Unusual circumstances or medical complications requiring additional time, skill, and experience in connection with a particular service or medical procedure.

The tool that made this possible was the computer with its ability to store and retrieve vast amounts of charge data. For the first time, it became possible to ask of a claim "Is it usual? Is it customary?". And receive answers that manual processors could not have provided. Affirmative answers result in individualized payment. Negative ones activate an individual consideration process that is part of all Blue Shield usual and customary program. Claims that exceed normal levels are reviewed first by medical staff and again, if necessary, by professional review committees, to evaluate special circumstances which might justify additional payment. The plans commitment, in such programs, is to payment in full, and extraordinary circumstances warranting extraordinary charges are anticipated and accommodated.

No responsible underwriter would offer—and no sophisticated consumer would buy coverage which purported to pay every medical fee, without limitation. Some control is necessary for the protection not only of the subscriber, but of the vast majority of physicians whose own honesty would be impugned by the abuse which such a program would invite. The basic question is in whose hands the control shall lie.

The new usual and customary program will provide the following benefits: Surgical services will be covered for all accepted operative and cutting procedures for the diagnosis and treatment of disease. Anesthesia benefits will be provided for anesthetics administered by a physician other than the surgeon or his assistant; Medical services will cover the cost of doctor visits to a bed patient concurrent with surgical or obstetrical care when such care is necessary. In-hospital medical care for mental and nervous conditions will also be paid on a usual and custo-

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Vitamin B_6	7.5 mg
Vitamin B_{12}	50 mcgm
Vitamin C	200 mg
Niacinamide	30 mg
Folic Acid	0.05 mg
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The Month in Washington

From the Washington Office
American Medical Association

Washington, D. C.—The American College of Radiology, defending the current use of x-rays by physicians, criticized published scare stories for causing unwarranted fears of x-ray examinations.

Dr. Richard H. Chamberlain, a spokesman for the college, said such articles as one in a recent issue of the Ladies Home Journal distorted the facts in such a manner that it added up to "one of the most tragic things in medicine" by scaring people as to the possible effects of being x-rayed. Dr. Chamberlain said usage of x-rays by physicians in this country is "remarkably good."

"The risks to patients in the performance for medical x-ray examinations are vanishingly small," he said. "Diagnostic x-ray examinations do not endanger the health of patients, despite a few shrill claims to the contrary. We could cite millions of instances where x-ray examinations provide life-saving information to patients."

The College supported in testimony before the Senate Commerce Committee a radiation standards bill, proposed after reports of radiation leaks from color television sets.

"The public has the right to expect protection against harmful amounts of inadvertent exposure to radiation from the operation of electronic devices," Dr. Chamberlain said.

He added that much more is known today about the effects of radiation than about many other environmental contaminants. Although more needs to be learned about the effects of low levels of radiation, he said, "we do know with assurance that their potential for harm is very small."

"The real tragedy occurs when even a single person may be misled by a distortion of radiation hazards to refuse a needed diagnostic x-ray examination," he said.

* * *

The Food and Drug Administration (FDA) has proposed new regulations for the classification of drugs found both safe and effective for their labeled uses in a survey of more than 3,600 prescription drugs.

The new procedures would open the way to increased competition within the drug industry by allowing firms to market drugs reclassified as "not new" or "no longer new" without submitting and awaiting approval of new drug applications (NDA) by the FDA.

A manufacturer that gets an NDA approval for a product has the right to market it exclusively. It is in effect an individual company license. Under the terms of the Food, Drug and Cosmetic Act, any medicine can remain in this "new drug" category regardless of how long it has been on the market.

The new proposal would set up a system for reclassifying the pre-1962 "new drugs" recognized as effective in the drug efficiency study being conducted for FDA by the National Academy of Sciences-National Research Council. The review, authorized by Congress in 1962, covers 3,690 drugs—every drug marketed in this country between 1938 and 1962. The drugs under review had been approved as "new drugs" solely on the basis of safety.

FDA announced that two drugs—metyrapone and metyrapone ditartrate—would be the first "new drugs" reclassified under the proposal. Both were found effective for their recommended uses of testing the functioning of the pituitary glands. They are manufactured by CIBA Pharmaceutical Co.

In its second report to carry out recom-

mendations of the study of every drug manufactured in the United States between 1938 and 1962, the FDA notified the manufacturer of a drug used in the treatment of severely painful menstruation to provide evidence within 60 days that the product is effective for conditions listed in its labeling. The drug lutrexin, manufactured by Hynson, Westcott & Dunning, Inc., of Baltimore, is available on prescription only.

The FDA also has issued a new warning about dangers of the antibiotic drug chloramphenicol.

* * *

Health, Education and Welfare Secretary Wilbur Cohen estimated that the medicaid program may cost the federal government between $2.5 and $3 billion in the fiscal year 1971.

The estimate for the next fiscal year (1968) is $2.1 billion. The original estimate for the current year was $1.7 but that proved substantially low and the administration has asked for $500 million more.

Congress has put some restrictions on the medicaid program, effective this July 1, and they may result in holding down the 1971 costs below Cohen's estimate.

The Social Security Administration reported that the medicare part B program, physicians' services, operated at a small deficit in fiscal 1967 which will be covered by the increases from $3 to $4 in monthly premiums.

The percentage of people 65 and over enrolled in the doctor bill insurance part of medicare went up from 92 to 95 per cent during the 6-month open enrollment period that ended April 1. About 700,000 older people who had missed out on their first chance to enroll signed up between October 1, 1967, and April 1 of this year. Now, 18.6 million of the 19.6 million persons 65 and over in the nation are now enrolled for medicare voluntary medical insurance.

Social Security Commissioner Robert M. Ball said that the overall social security fund is in good fiscal condition. Medicare received $3.1 billion in fiscal 1967 and disbursed $2.6 billion, Ball said. He said estimates for the next 25 years showed that the program "has a favorable actuarial balance—namely, that total income over the 25 years ahead is expected to exceed total outgo."

Cohen told a House appropriations subcommittee that HEW was very much concerned and was making an intensive investigation of reported abuses by some physicians in federal medical programs.

He said a number of allegations had been made but that he would not want to make an overall statement until the investigation was completed.

"A typical kind of allegation concerns a doctor who goes into a nursing home—I will be just hypothetical about this—and he is there for an hour and then sends in a bill for an injection of something for every one of 50 people in the institution," Cohen said.

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"Then we have had cases of bills being submitted in which the evidence suggests that the volume of services that he is requesting to be paid for is beyond the ability of a particular person to handle. Well, he comes back to that allegation and says, 'I have a nurse and I have an assistant' and so on. So we have to look into each one of them on their merits. We are doing that now.

"The popular criticism usually has to do with the individual fee. I really don't think that is the major issue. The real issue is not so much the fee or the price per unit, but the number of units that the person is saying he delivered."

Cohen said he did not think such practices are widespread but that:

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A preliminary injunction was issued to halt the sale of a diathermy device distributed by the Diapulse Corporation of America.

The U. S. District Court for the Eastern District of New York, enjoined sales of the Diapulse device, advertised for treatment of 49 diseases and conditions, including tuberculosis, typhoid fever, staph infections, and gangrene.

The diapulse device was seized by FDA in 1965, and found to be misbranded on March 17, 1967, by a Federal court in Hartford, Conn., but the sale of the machine continued pending further appeals.

* * *

A group of physicians specializing in child health has endorsed a bill to require special safety containers for drugs, soaps and other household products involved in the poisoning of 500,000 children each year.

The Accidental Poisoning Committee of the American Academy of Pediatrics endorsed the measure sponsored by Chairman Warren G. Magnuson, D-Wash., of the Senate Commerce Committee. The Academy, in a letter to Magnuson, said the bill was the only "practical way to eliminate hazards from drugs and household products."

The government announced a ban on interstate shipment of household products containing carbon tetrachloride—a substance used in some cleaning fluids.

The Food and Drug Administration (FDA) said use of the chemical in a home constitutes a hazard to public health and added there are many safer substitutes available. According to the FDA, carbon tetrachloride can be fatal if the fumes are inhaled. The chemical can also cause damage to the liver, kidneys, brain and nervous system, the agency said.

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Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in m instances by proper dosage adjustment, b also occasionally observed at the lower d ranges. In a few instances syncope has be reported. Also encountered are isolated i stances of skin eruptions, edema, minor strual irregularities, nausea and constipa extrapyramidal symptoms, increased and creased libido—all infrequent and genera controlled with dosage reduction; change EEG patterns (low-voltage fast activity) appear during and after treatment; blood crasias (including agranulocytosis), jaun and hepatic dysfunction have been repor occasionally, making periodic blood cou and liver function tests advisable during tracted therapy.

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References:

(1) Siver, R. H.: CMD, *21*:109, September 1954. (2) Frykman, H. H.: Minn. Med., *38*:19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., *51*:16-18, January 1955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., *15*:15-16, October 1965. (5) Weekes, D. J.: N.Y. State Jour. Med., *58*:2672-2673, August 1958. (6) Weekes, D. J.: EENT Digest, *25*:47-59, December 1963. (7) Abbott, P. L.: Jour. Oral Surg., Anes., & Hosp. Dental Serv., 310-312, July 1961. (8) Rapoport, L. and Levine, W. I.: Oral Surg., Oral Med. & Oral Path., *20*:591-593, November 1965.

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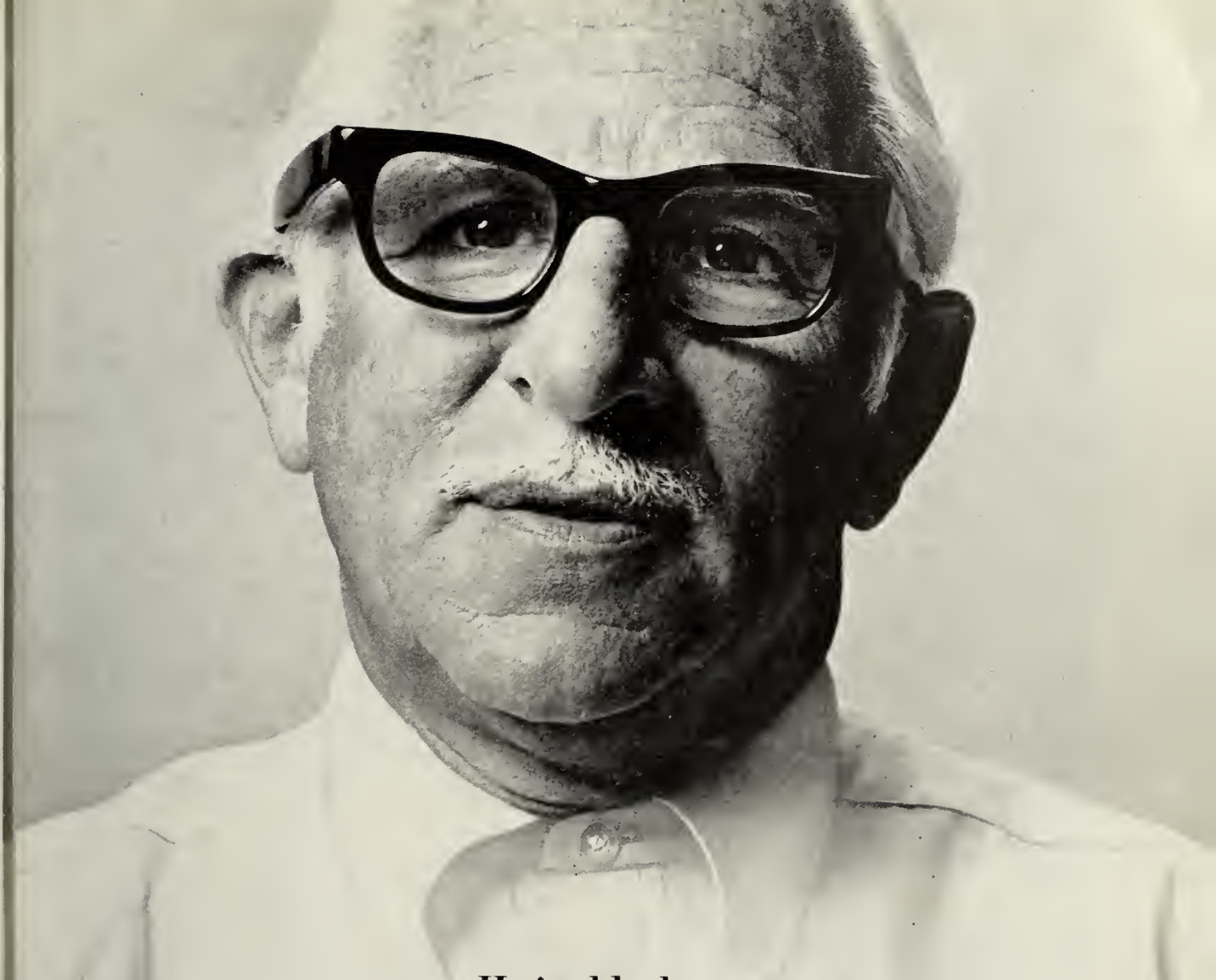
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Locations Wanted

Anesthesiology—

Age 37; University of Pittsburgh, 1957; seeking group or associate practice. Available October 1968. LW-334

General Practice—

Age 27; Louisiana State University 1967; seeking group or associate practice. Available August 1968. LW-335

Age 38; University of Oklahoma, 1955; seeking associate, institutional or industrial practice; in town of 10,000 plus population; interest in surgery. LW-336

Age 28; University of Tennessee, 1965; available November 1968. LW-337

Age 28; Medical College of Alabama 1966; seeking practice in town of less than 14,000 population to fulfill scholarship requirements. Available 1968. LW-338

Age 52; University of Chicago 1950; seeking group, industrial, institutional or student health position. LW-339

Age 56; Georgetown University 1938; seeking solo, group or associate practice, with general surgery. Available July 1968. LW-340

Internal Medicine—

Age 34; Hahnemann Medical College 1959; Board eligible, National Board; seeking solo, group, or associate practice. Available immediately. LW-342

Age 34; University of Tennessee, 1958; American Board Certified, seeking group, industrial, or institutional practice. Available Spring 1968. LW-343

Neurology—

Age 31; Harvard 1962; Board eligible; National Board; seeking solo, group or associate practice. Available July 1969. LW-344

Age 30; Medical College of Alabama 1962; Board eligible; National Board; seeking solo, group, associate or institutional practice. Available January 1969. LW-345

Obstetrics-Gynecology—

Age 35; Vanderbilt University 1950; Board eligible; Available July 1968. LW-346

Age 37; University of Virginia 1959; Board certified; seeking group or associate practice. Available September 1968. LW-347

Age 34; University of Missouri 1959; Board certified; seeking group, industrial, associate or institutional practice. Available July 1968. LW-348

Age 36; Medical College of Alabama 1957; Board eligible; seeking group or associate practice. Available immediately. LW-348-A

Radiology—

Age 31; S. U. N. Y. College of Medicine, 1961; Board eligible; seeking solo, group, or associate practice. LW-350

Age 41; Cornell Univ. Medical School, 1953; Board certified; seeking group, or associate practice. Available immediately. LW-351

Age 51; Univ. of Texas Med. Branch, 1942; Board certified; seeking solo, group, or associate practice. LW-352

Surgery—

Age 33; University of Missouri, 1961; seeking group or associate practice. Available January 1969. LW-353

Age 38; Emory University, 1956; Board eligible; seeking group, associate, or institutional practice. Available July 1968. LW-354

Age 37; Faculty of Medicine, Manitoba, 1957; Board certified; seeking associate or institutional practice. Available July 1968. LW-355

Age 34; Board eligible; University of Santo Tomas, 1961; seeking group or associate practice. Available July 1968. LW-356

Age 35; Board eligible; Univ. of Santo Tomas, 1956; seeking solo, group, industrial or associate or institutional practice with general practice. Available immediately. LW-357

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General Practitioners—

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For town of approximately 1,000 population in North-central Alabama in trade area of 12,000 population. 100-bed hospital in adjoining city. PW-216

For town of 12,500 population in trade area of 50,000 located in South Alabama. Nearest large city with population of 145,000 is 80 miles. One of the physicians died recently. Two hospitals with 140 beds. Numerous small industries; several churches and schools. Recreational activities include water sports and golf course. PW-217

For town of approximately 1,000 population in population center of 10,000 located in Southwest Alabama within 90 miles of the Gulf coast. City owned clinic is offered rent free and fully equipped. Hospitals are located in two nearby towns within 25 miles. This is principally an agricultural region, but there are military installations nearby. Numerous civic clubs, community concert series, and a country club offer recreational activities. PW-218

For town with 1,000 population in trade area of 5,000 Southeast Alabama. Nearest large city with population of 50,000 is 55 miles. New clinic available rent free. No physicians in the town. Hospitals in surrounding town within 30 miles. Several churches and schools. PW-219

Opportunity in city of 5,000 population located in Northeast Alabama in trade area of approximately 10,000 population. Office space available. One physician died recently. Hospital and nursing home in the city. PW-220

For town of 1,000 plus population in west-central Alabama in trade area of 20,000. Clinic available. Nearest city of approximately 70,000 population is located a distance of 17 miles. Farming, cattle, timber, and manufacturing plants are principal resources of the area. Churches, schools, and recreational advantages. PW-221

For solo practice in town of approximately 17,000 population located in east central Alabama. 48-bed general hospital. Arrangements available for office space. Excellent recreational advantages which include hunting, fishing and water sports. City owned airport. Numerous civic clubs. Excellent schools and churches. Expanding industrial and agricultural area. PW-222

Opportunity for one or more doctors in rapidly expanding eastern suburb of Birmingham. Attractive brick building consisting of 10 rooms and adjacent parking facilities. PW-223

Opportunity for general practitioner to join a five-man group, practicing as a partnership. Each man in the group is either specialized or semi-specialized. The practice is physically located within a 70-bed hospital. Willing to pay qualified person $36,000 for the first year, with possible partnership status in one year. Would consider a physician for locum tenens for three to six months at $2,000 per month. PW-224

Opportunity in centrally located town in North Alabama in trade area of 10,000-15,000 population. The only doctor is retiring. Housing and office space readily available. Churches and schools. Recreational advantages of nearby lakes. PW-225

Surgeon—

Opportunity for a Board eligible or Certified surgeon to practice in city of over 78,000 population in north Alabama. Equipment available. PW-226

Special Openings

Specialist in the following fields: Internal Medicine, Pediatrics, Obstetrics-Gynecology and General Practitioners. 58 bed fully accredited general hospital with 91 bed addition to be completed in July 1968. Modern new office space available. PW-227

Medical Superintendent of 225 bed tuberculosis sanatorium with a building program in Birmingham. Salary and job description negotiable. Must be able to obtain Alabama license. PW-228

Physician interested in Internal Medicine and Chest Diseases to provide general medical services in 184 bed Tuberculosis Hospital in North Alabama. References and experience data required in advance. U. S. citizens and fully licensed physicians given first choice. Others will be considered upon request. Salary open. PW-229

President's Page



E. L. McCafferty, Jr.

I am sure that each of you joins with me in congratulating Dr. and Mrs. John M. Chenault on having been elected to their responsible positions with our National Organizations.

Mrs. Chenault was elected the President-Elect of the Woman's Auxiliary to the American Medical Association and will be installed as its President at the 1969 Convention in New York City.

Dr. Chenault was elected to the Board of Trustees of the American Medical Association at the recent meeting in San Francisco.

These are singular honors and Alabama can be proud to have two such distinguished members to serve in these important positions.

Besides the pleasure that we feel in having the abilities of our members recognized, there is also a great advantage to us in knowing that we are represented and that our voices and personal influence will be transmitted through our representatives at the highest level of decision. It therefore behooves all of us to become more involved in our State and county societies, and to participate fully in all of their discussions so that whatever sentiment prevails we can at least have contributed our particular share to the final conclusion. Of course, I realize as you will, that Dr. and Mrs. Chenault will endeavor to represent all of the doctors and their wives and through discussion and reason try to arrive at a program that will promote the welfare of the entire population of our country and the best interest of the medical profession and its Auxiliary.

In an effort to promote communications between the county societies, their individual physicians and the State Association, it has been proposed to have regional meetings of the Board of Trustees. These plans are being formulated and it is hoped that at each of these meetings we will have full representation of each county society and full discussion of any problems that we can be helpful in solving.

At the next meeting of the Board of Trustees, a representative of the American Medical Association has been invited to meet with us and help us in formulating a program of better public relations between the physicians and their patients, and also closer liaison between the medical students, the interns and residents who anticipate practicing in our State. It is somewhat difficult for me to think that the so-called "generation gap" is as wide as we are led to believe; however, since these young men and women will soon participate in our deliberations, it is most important that we understand their point of

(Continued on Page 102)

The muscle relaxant that works before you write a prescription

Relieve painful skeletal muscle spasm in your office in minutes with a single 2 cc. injection of NORFLEX. Then, for sustained relief, write a prescription for NORFLEX tablets, 1 tablet b.i.d.

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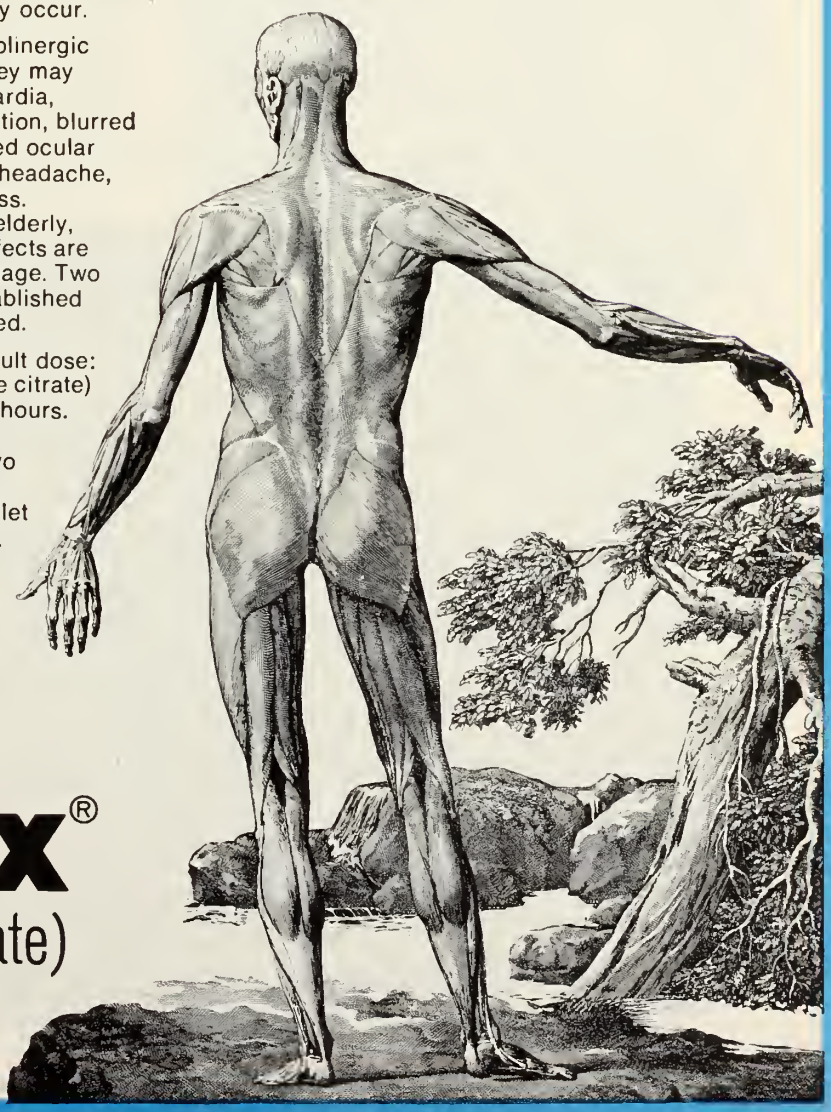
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DOSAGE: **INJECTABLE** — Average adult dose: one ampul, 2 cc. (60 mg. orphenadrine citrate) I.M. or I.V. May be repeated every 12 hours. Relief may be maintained with one NORFLEX tablet b.i.d. **TABLETS** — Two tablets per day for adults, one in the morning, one in the evening. Each tablet contains 100 mg. orphenadrine citrate.

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Norflex®
(orphenadrine citrate)

(Continued from Page 100)

view and begin to accept those ideas that they propose which will help us toward being a stronger organization and responsive to the wishes of all of the doctors.

It would seem to me that if we can all become involved in the affairs of organized medicine, unified in our efforts to build a strong organization responsive to the needs of the individual physicians, this year's efforts will be most rewarding.

E. L. McCafferty Jr.

Judicial Council Rules On Patient Information

Is it proper for a physician to discuss his patient's medical condition, disease or illness with the press?

According to the AMA Judicial Council's opinion adopted in November, 1967, a physician's obligation is to his patient.

However, a patient, by virtue of his position, may have an obligation to others such as stockholders or voters to whom he may be responsible. If such an obligation exists, the disclosure of health knowledge must come from the patient, not the physician. The physician should insure the medical accuracy of any authorized report.

In summary, it is the opinion of the Judicial Council that a physician may not discuss the patient's health condition with the press or the public without the patient's consent or, in the event of his incapacity, the family's consent.



The Woman's Auxiliary

President, Mrs. R. K. Wilson, Sr.
President-Elect, Mrs. B. H. Johnson, Jr.
Northeast District Vice President, Mrs. Eugene H. Bradley
Northwest District Vice President, Mrs. Gene Qualls
Southeast District Vice President, Mrs. George Andrews
Southwest District Vice President, Mrs. G. William Wiles
WAMASA Editor, Mrs. William L. Smith

AUXILIARY PLEDGE

"I pledge my loyalty and devotion to the Woman's Auxiliary to the American Medical Association. I will support its activities, protect its reputation and ever sustain its high ideals."

Having just returned from the National Convention in San Francisco, I want to share some of the highlights of the meeting with you. It was a successful Convention in every respect, and the red carpet was really rolled out for us by the California Auxiliary.

The meeting was held at the lovely St. Francis Hotel, and it attracted a registration of 1,741. Mrs. Karl Ritter, who has served most ably as President for the past year, presided.

The Keynote Address was presented by Mr. Philip Lesly, president of the Philip Lesly Company, an authority on Public Relations, whose subject was "How Can We Prevent Being Defeated by Success?" He spoke of the fact that medicine is faced with many problems today created by its own success. He stated that when you succeed at anything, you improve things, and improvement automatically creates change. Then our challenges must be adjusted to the changes that we have brought about. He said, "Professional seclusion was part of the picture of medicine's less fruitful years. A price of its success is involvement with the whole mechanism of the world it functions in. You and your husbands must become opinion leaders and motivators in the new structure. The doctor's wife should become active politically, and be sure that your husband joins the PACs, too. Never was there so clear a chance to make yourself felt as a citizen."

At the luncheon honoring the past presidents, Dr. Rouse spoke on the subject "The Physician's Finest Hour." The Auxiliary's annual contribution to the AMA-ERF amounted to $389,824.64.

At the Guest Day Luncheon, where women who are leaders of volunteer organizations were honored, the guest speaker was Henrik L. Blum, M. D., who is Clinical Professor of Community Health Planning, School of Public Health, University of California at Berkeley. He presented a very knowledgeable discussion on "Program Planning and Implementation."



Mrs. Robert K. Wilson, Sr.

One of the most interesting portions of a National Convention is always the reports of the Auxiliary presidents from the 50 states, and the members never cease to marvel at the accomplishments of doctors' wives throughout the nation.

At the Installation of Officers, Mrs. C. C. Long, Arkansas, became the new President,

(Continued on Page 104)

and we of the Alabama delegation were especially proud when Mrs. John Chenault, Decatur, was installed as President-Elect.

This was our first visit to San Francisco for my husband and me, and we were very much impressed with the beauty and cleanliness of the city, as well as the friendliness of the people. We enjoyed a tour of Chinatown at night, and a dinner at a Chinese Restaurant; a lobster dinner at Fisherman's Wharf, and a two hour tour of the city on the afternoon before coming home. We were told that there are 45,000 Chinese, 30,000 Japanese, and 50,000 "Hippies," who were very much in evidence throughout the city. We returned home refreshed, better informed, and better prepared to face the challenges of the year ahead.

Louise M. Wilson

(Mrs. Robert K. Wilson, Sr.)
President WAMASA

Continuing Education Courses

September 22, 1968
Alabama Diabetes Meeting, Birmingham

October 13-18, 1968
Practical Aspects of Respiratory Care and Pulmonary Rehabilitation

October 14-25, 1968
Advanced Radioisotopes Training Course

Information regarding these courses may be obtained from the office of Dr. Margaret S. Klapper, Director, Division of Continuing Medical Education, Medical College of Alabama, 1919 7th Avenue, South, Birmingham, Alabama 35233.



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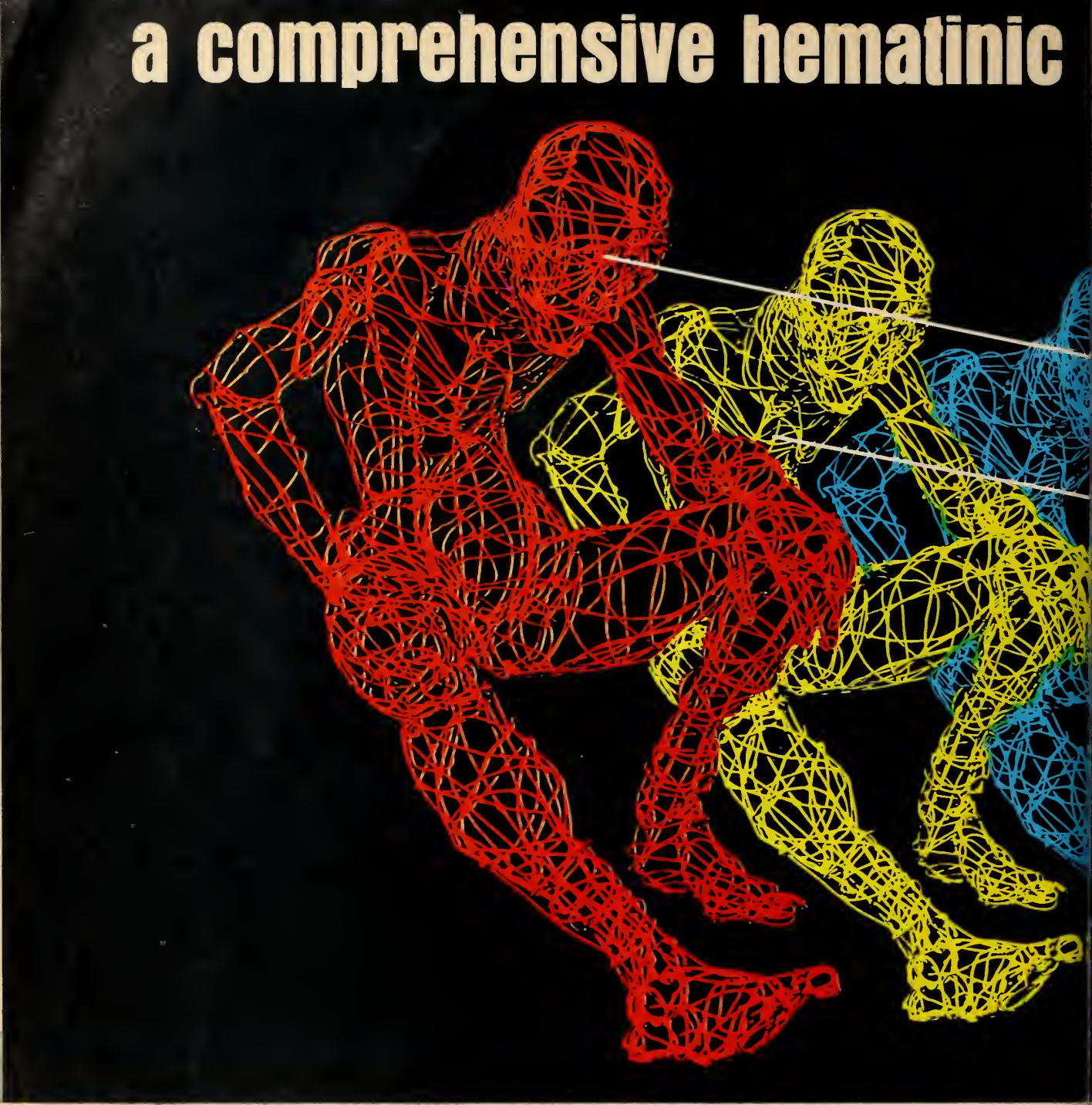
The *prolonged* acceptance of Mylanta was recently confirmed in 87.5% of 104 patients—after a total of 20,459 documented days of therapy.* *Danhof, I. E.: Report on file.

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Description: Each Pulvule® contains—

Special Liver-Stomach Concentrate, Lilly (containing Intrinsic Factor)	150	mg.
Cobalamin Concentrate, N.F., equivalent to Cobalamin (The total vitamin B_{12} activity in the Special Liver-Stomach Concentrate, Lilly, and the Cobalamin Concentrate, N.F., is 15 micrograms.)	7.5	mcg.
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Ascorbic Acid (Vitamin C)	75	mg.
Folic Acid	1	mg.

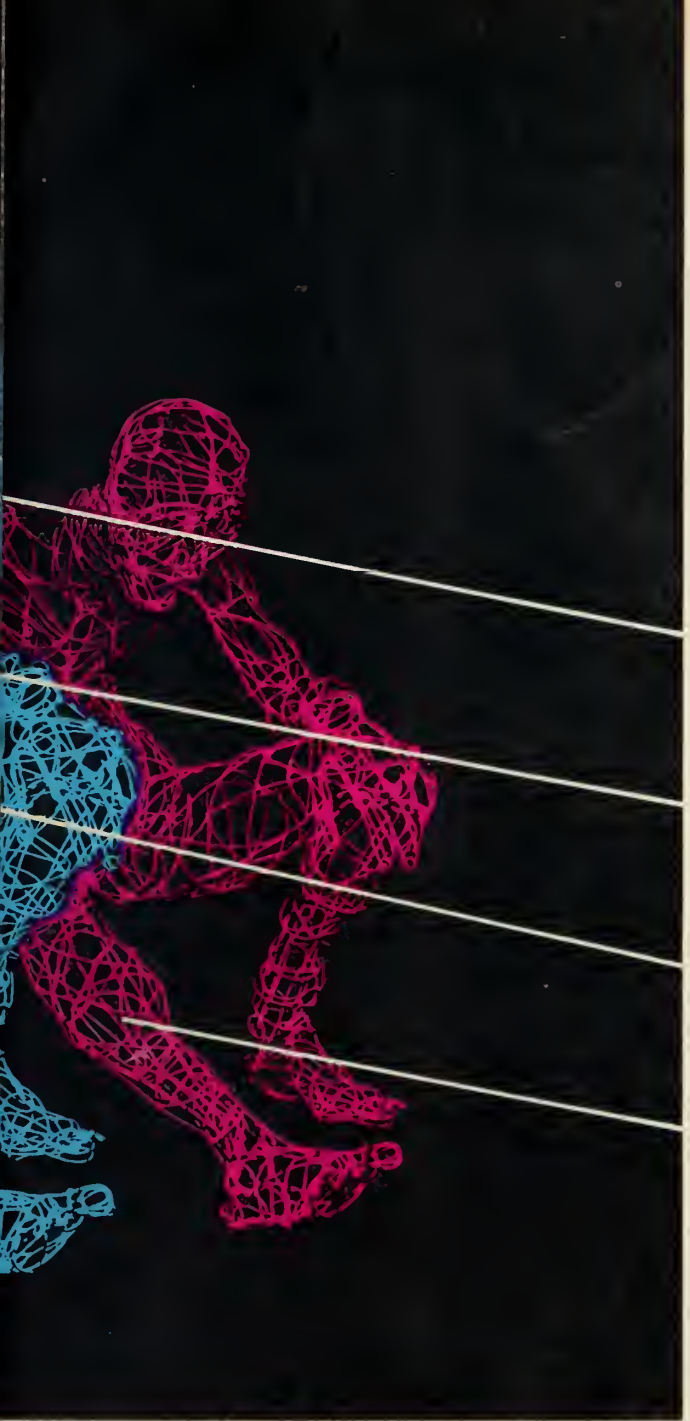
Indications: Trinsicon® (hematinic concentrate with intrinsic factor, Lilly) is a multifactor preparation effective in the treatment of anemias that respond to oral hematinics, including pernicious anemia and other megaloblastic anemias and also iron-deficiency anemia.

Contraindications: Hemochromatosis and hemosiderosis.

Precautions: Anemia is a manifestation that requires appropriat investigation to determine its cause or causes.

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Recognition Well Deserved To Alabama Citizens

The Journal would add its hearty congratulations to the hundreds of others which have been accorded to three members of the family of physicians in Alabama who have received deserving recognition in the highest councils of organized medicine.

First we extend our accolade to Mrs. Belle Montgomery Chenault of Decatur upon her election by acclamation to the office of President-Elect of the Woman's Auxiliary to the American Medical Association. That this mantle of responsibility should be placed upon the shoulders of one of the Auxiliary's most effective leaders is testimony to the respect and esteem in which she is held throughout this nation.

Belle Chenault is no stranger to the physicians of Alabama who have participated in organization affairs at the state, regional or national levels. She has held the highest office in the Auxiliaries of the Medical Association of the State of Alabama and the Southern Medical Association. Her intense interest in all matters affecting the practice of medicine has been demonstrated over a long period of years and her election by the AMA Auxiliary naturally invokes the conviction that this organization, during her tenure as President, will march forward to new heights.

Secondly, we congratulate John Morgan Chenault of Decatur upon his election over exceedingly strong opposition to the highest governing body of the American Medical Association—the Board of Trustees. Into this responsible office Dr. Chenault will take with him the benefit of long experience as a member of the Board of Censors of the Medical Association of the State of Alabama which, as everyone knows, also constitutes under Alabama law the State Committee of Public Health and the State Board of Medical Examiners.

Now entering upon his second year as Chairman of the Board of Censors, Dr. Chenault probably has a keener insight into the virtues and vicissitudes of medicine—scholastic, clinical and preventive—than any other member of the AMA Board of Trustees. He can be depended upon to make his broad experience available to other members of the Board. His election, by a comfortable margin, is proof positive that the AMA is moving ahead with deliberate speed and determination to confront the demands of the times without fear and without panic.

The election of "just a country boy from the hills of North Alabama" to the most responsible council of the American Medical Association should demonstrate positively to all Alabama physicians that AMA is striving to serve their interest and that those among us who withhold their support from AMA are guilty of gross ignorance of its purposes or callous indifference to the future of their profession.

Thirdly, we congratulate E. Bryce Robinson, Jr., of Fairfield upon his re-election to a five-year term on the AMA Council on Medical Education. At a convention when the AMA House of Delegates sought to replace the least effective of its leadership with men

of superior ability and foresight it is especially significant that Dr. Robinson was re-elected to the Council on Medical Education without opposition.

It is common knowledge that one of the major problems of health care in this nation is the acute shortage of physicians, a problem which can be overcome only by increasing medical education facilities. Dr. Robinson and the other members of the Council have long been laboring to overcome this deficiency. There is little doubt that before his new term expires, Dr. Robinson and the Council can point with pride to new and expanded educational facilities which to date are but a dream.

The Medical Association of the State of Alabama can take great pride in its delegation to the AMA. In addition to the high honors accorded Drs. Chenault and Robinson, it should be noted that the third member of the delegation—M. Vaun Adams of Mobile—was called upon once again to serve as a member of one of the House of Delegates' reference committees. To these reference committees are referred all reports of councils, committees and officers as well as all resolutions submitted for consideration at the Session. The reference committees hold open hearings on all matters assigned to it at which time any member of the American Medical Association is free to present his views, pro or con. Upon conclusion of the open hearings, the committee enters into its deliberations and renders a report of its determinations to the House of Delegates. Often it is a thankless and laborious assignment lasting long into the night.

Dr. Adams served on the reference committee to which was assigned all matters dealing with physician-hospital patients. With the advent of Medicare and Medicaid and expansion of voluntary as well as compulsory health insurance programs, it is inevitable that the hospital-physician relationship will undergo many stresses in the years ahead. It is proper that the AMA recognize this fact by designating a single reference committee to study encumbent problems and resolve them before they become major stumbling blocks.

What If Disaster Strikes?

It would appear that the time has long since passed when the State of Alabama should have a comprehensive emergency disaster plan which would catalogue, in detail, the functions and responsibilities of all concerned.

While this State has been fortunate in escaping natural or man-made disasters of major proportions we cannot assume that this will always be the case. The lessons learned from other of these United States should teach us that no man can predict when or where disaster will strike.

Just within the past year we have read of the collapse of a steel bridge linking Ohio to West Virginia, tornadoes have devastated heavily populated urban areas, explosions have occurred in industrial plants and even a circus tent has collapsed under the pressure of high winds. In these and the hundreds of other disasters which have afflicted this nation in recent years the toll of killed and injured mounts to the thousands.

Without detracting from the effective work of the Civil Defense organization or the American Red Cross, it is safe to speculate that only Birmingham (and possibly Mobile) could cope with a disaster of major proportions requiring large numbers of medical and paramedical personnel in attendance upon short notice. And even then it is doubtful that Birmingham could cope with a major

disaster in which hundreds of people required medical attention if it occurred at such an inopportune time as the middle of a night on the weekend.

Communities which have been confronted with major disasters have been astounded by the number of peripheral problems they produced. For instance, when President John F. Kennedy was assassinated in Dallas such a heavy burden was placed upon the telephone system of Washington, D. C. in the first minutes that a city-wide breakdown of telephone service ensued for several hours. Similarly, when the Silver Bridge collapsed, the telephone system of nearby Gallipolis, Ohio, was unable to handle the deluge of calls from anxious friends and relatives and the lines went silent. This made it impossible for the two hospitals of Gallipolis to summon the doctors, nurses and other hospital personnel needed to cope with the flood of patients then arriving.

Fortunately, the Mid-Ohio Valley Industrial Planning Council had prepared for many of the problems which can be anticipated from a major disaster. Hospitals, physicians, nursing staffs, technologists and all others needed to meet the emergency had been prepared in advance. Here are some of the results:

The dietary department immediately began preparing food in the form of coffee, sandwiches, etc. to feed the staff, victims, relatives and rescue workers.

Outside the hospital, space had been cleared for arrival of emergency vehicles.

Operating personnel had one operating room ready with one surgical team fully manned. Second, third and fourth operating rooms were in the process of preparation.

Laboratory personnel were ready with approximately 30 units of blood on hand and 18 units of frozen plasma starting to thaw. A blood donor station was set up.

Hospital administration established an information service to aid in the identification and admission of victims.

A morgue was set up at a church across the street from the hospital.

An information center for relatives and others making inquiries was established at another church next door to the hospital. Some personnel was stationed around the hospital to direct traffic and to assist the public.

Some lessons were learned from the Silver Bridge disaster which could prove beneficial to others responsible for advance planning. The possible breakdown of the telephone system is a real factor and the use of commercial, public and private radio services should not be overlooked. There should be immediately available walkie-talkie communications equipment for use within and outside the hospital.

The responsibility for coping with a disaster should rest with all segments of the community for it transcends the functions of the health team. Also needed in this emergency are the full resources of law enforcement, fire fighting, rescue and transportation organizations. A command post should be established quickly, manned by law enforcement and medical staffs, to direct the movement of rescue workers to the scene of the disaster as well as the transportation of victims to the nearest hospital with adequate facilities.

Here in Alabama it is obvious that no single community could render immediate and total emergency care in the event of a catastrophic disaster in which hundreds of persons were injured. Therefore, it behooves this Association to take the leadership, with the support of the Governor, the appropriate State agencies, hospital administrations and paramedical personnel to prepare in advance for an eventuality which we all pray will never occur.

Physicians of Lowndes County

The predominantly rural county of Lowndes has been prominent in Association news since the office of Economic Opportunity (OEO) proposed a new and startlingly different federal health program. As high as 85 per cent of the population could receive free medical and other health care under the program. Yet, Lowndes County has only three physicians, one relatively young, one relatively old but active, and one a retired naval officer without a practice. This is in mid-1968.

It is interesting to look into history and see what the medical profession was like in Lowndes County 100 or 50 years ago. The comparison is indeed interesting.

Dr. Andrew Bowie, a physician and surgeon of Benton, was born in 1830 in Edgefield, South Carolina. His father, Dr. Samuel W. Bowie moved with his family to Lowndes County in 1835 and practiced medicine there for 40 years. Dr. Andrew Bowie studied six years at the University of Georgia, and received his medical degree from Charleston Medical College in 1854. He practiced many years in Lowndes. He was a member of the Medical Association. One of his relatives, James Bowie, was the inventor of the Bowie knife. He went to Louisiana where he was killed in a fight by a knife—a bowie knife. Dr. Andrew Bowie lived until about the turn of the century.

Dr. Philip Noble Colley was a practicing physician in Lowndesboro. He was born in New Hampshire in 1821. He taught school in his native state, in South Carolina, and in Macon County. In 1846 he moved to Lowndes County, and read medicine under Dr. Wooten of Lowndesboro. He graduated from the University of Louisiana, now Tulane University, at New Orleans. He returned to become a partner of Dr. Wooten who shortly thereafter moved to Tennessee to accept a professorship in medicine at the Memphis Medical College. Some of Dr. Colley's ancestors came from the Isle of Man.

Dr. Joseph T. Hearne was born in 1819 in what was later to become Lowndes County. His parents came from Georgia to Alabama in 1818 and literally settled in the woods near the present town of Lowndesboro. Dr. Hearne graduated from the University of Pennsylvania in 1844. He practiced in Lowndesboro until 1857 when he retired to tend to his plantation interests. During the War Between the States, Dr. Hearne again took up his practice of medicine tending to the needs of his neighbors. He lived to a very advanced age dying after the turn of the century.

Dr. Daniel Stiles Hopping of Letohatchee was born in Georgia in 1830. He was educated at Athens, Georgia, where his father was a professor in the State University. He received his medical degree from Jefferson Medical College, Philadelphia, in 1852. Except for a period during the War Between the States when he was with Bragg's Army, he practiced in Lowndes County. He was a vice-president of the Medical Association and was a Counsellor.

Dr. Malcomb McPherson was the son of a pharmacist of Fort Deposit. He was killed near Chattanooga while serving as surgeon in the Confederate Army.

Dr. Edward Hill Pritchett, a native of Virginia, graduated in medicine from the University of Pennsylvania in about 1846. He came to Lowndes County where he spent the rest of his life. His son, Dr. John A. Pritchett, was born in 1849 near Hayneville. He received his medical degree from the University of Virginia in 1870, and thereafter practiced medicine in Hayneville for the remainder of his life.

Dr. John H. Russell of Sandy Ridge was born in that community in 1833. He attended Emory College (now Emory University) in

Georgia, the University of Tennessee where he was valedictorian of his graduating class. He read medicine with a cousin, after which he attended the Reformed Medical College of the South, Macon, Georgia. Thereafter he attended and graduated in medicine from the Metropolitan College of New York. He practiced briefly in Sumter County, Georgia, and in Union Springs, Bullock County, Alabama, before settling permanently in Sandy Ridge.

Dr. Charles Taliaferro Weatherly of Benton was born in Georgia in 1852. His father, Dr. Job S. Weatherly, a graduate in Medicine from the University of New York, came to Montgomery in 1857. The senior Weatherly (Job) was president of the Medical Association of the State of Alabama in 1875, and was vice-president of the American Medical Association. Dr. Job Weatherly died in 1891. The younger Dr. Weatherly graduated from the University of the South at Sewanee, Tennessee in 1870. He attended Louisville Medical College in 1871 and 1872. Following this, he attended Charleston Medical College for one year and graduated from Atlanta Medical College in 1874. He returned to Alabama and settled in Benton where he practiced for the remainder of his life. He was a member of the Medical Association of the State of Alabama and served on the Board of Censors of his constituent Society.

No comparison should be made between medicine in Lowndes County up until and into this century and that of the present time based on numbers of physicians or numbers of patients. It can be hoped that populations of the past received the best care available in the era. If the illustrious list of physicians available, and there may have been others, is any indication, Lowndes was indeed fortunate. Lowndes may be fortunate again. Only history will tell.



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One tablet of QUINAMM at bedtime usually controls distressing night cramps and permits restful sleep with the initial dose.

Prescribing information—Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Side Effects/Precautions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

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Winner Of Pathology Award Proposes New Theory On Cancer

A new theory on the way cancer grows relatively unregulated out of normal cells was presented to the American Society for Experimental Pathology by Dr. Henry C. Pitot, professor of oncology and pathology at the University of Wisconsin School of Medicine.

In his lecture as winner of the Society's annual Parke-Davis Award, Dr. Pitot described some of his studies in experimental liver cancers of rats which have led him to suggest that the growth of cancer cells is the result of an alteration in the cell's regulatory mechanism and that this mechanism may be independent of the direct action of the cell's genes. Not only does cancer arise as a result of malfunction of this mechanism, Dr. Pitot argued, but the alterations of this mechanism are unique to each particular cancer.

The concept, if it is correct, may well open the door to an understanding of the development of cancer at the level of the molecule. It was for this and previous contributions to cancer research that Dr. Pitot was presented with the $1,000 award which is given each year to an ASEP member under 40 who has made the "greatest contribution to the conquest of disease."

Dr. Pitot, 37, both an M. D. diplomate in anatomic pathology and a Ph. D. in biochemistry, reported experiments which indicated that the mechanisms which regulate the synthesis of liver enzymes may function independently of direct genetic expression. He believes that the regulation of certain gene functions are indirectly accomplished through enzyme-forming units which occur in association with a structure inside cells known as the endoplasmic reticulum.

Dr. Pitot calls these units *Membrons*—a sort of package word that describes the membrane of the endoplasmic reticulum and the molecule of messenger RNA associated with it, which together comprise the cytoplasmic counterpart of the *Operon*—a concept of gene regulation first proposed by the French Nobel Prize winning scientists Jacob and Monod.

Membrons, Dr. Pitot said, are functioning stable units independent of the gene. They regulate the cell by interaction with the environment. Dr. Pitot has found that the stability as well as the number of *Membrons* in cells of a specific liver cancer seem to be different from those seen in a normal liver cell and that the population of *Membrons* may be unique to that particular cancer.

These findings suggest, he said, that liver cancer is the result of heritable alterations in the stability and regulation of intracellular *Membron* units that may not directly involve the genetic material of the cell.

This may explain the widely varying characteristics—*phenotypes,* as scientists refer to them—which appear to be characteristic of experimental liver cancers. Dr. Pitot further suggests that his findings in liver cancers may also be true in many other types of cancer.

Cancer, in his view, therefore becomes a disease of the *Membron,* that is, a disease of differentiation which in itself is dependent on the *Membron* population. Thus, the altered regulatory mechanisms which reflect the characteristic altered biology of the cancerous cell may be the result of altered regulation of genetic expression. This, in turn, is in part a consequence of changes in the mosaic of membrane structure in the cell that are induced by the environment.

AMA Panel Develops Foreign Graduate Policy For Interns, Residents

Last July the AMA's Department of Graduate Medical Education issued the "Policy of Eligibility of Foreign Medical Graduates for Appointment to Approved Internships or Residencies," a memo directed to all hospitals with approved graduate training programs, state society secretaries and state boards of medical licensure. It restated the American Medical Association's policy regarding the eligibility of foreign medical graduates for appointment to approved internships or residencies as follows:

"Graduates of all medical schools outside the United States and Canada should establish their eligibility for appointment to an approved internship or residency program through:

A. Certification by ECFMG on a basis of satisfying the ECFMG educational requirements, as well as passing the ECFMG examination, **or**

B. Obtaining a full and unrestricted license to practice medicine, issued by a state or other United States jurisdiction authorized to license physicians, **or**

C. In the case of United States citizens, successfully passing the complete licensure examination in any state or other licensing jurisdiction in which the law or regulations provide that a full and unrestricted license to practice medicine in that state or jurisdiction will be issued to the physician after satisfactory completion of his internship or residency in that state, without further examination."

Although not stated in this memo, it was intended that these policy statements apply only in those cases in which a foreign medical graduate is defined in the terms set forth by the Educational Council for Foreign Medical Graduates.

"In other words, to be eligible under C. above, the foreign medical graduate must have completed all requirements that would make him eligible for ECFMG certifications should he choose to apply.

"The above policy has particular application to United States citizens who are graduates of schools in Mexico. Such individuals who may have finished their formal course work and received a 'Carte de Pasante' are **not** considered to be graduates of those schools until they have completed their periods of clinical work and social service, passed the final examinations, and received the degree of 'Medico Cirujano.' In the case of graduates of other medical schools outside the United States and Canada, all state boards of licensure are advised to follow the ECFMG's criteria for graduation if they wish to accept United States citizens under the provisions of C. above.

"Hospital administrators and directors of graduate programs are cautioned not to confuse the policies of state boards of licensure with those of the AMA regarding waiver of ECFMG requirements. Although some state boards of licensure may waive their own ECFMG requirements for licensure purposes, they may still require that a candidate serve an approved internship or residency. Thus, the waiver for purposes of subsequent licensure should not be misconstrued to mean that the AMA has waived its requirement for ECFMG certification as a prerequisite for appointment to approved internships and residencies."

Calendar of Annual Meetings

Medical Association of the State of Alabama

1969, April 24-26, Carriage Inn, Huntsville

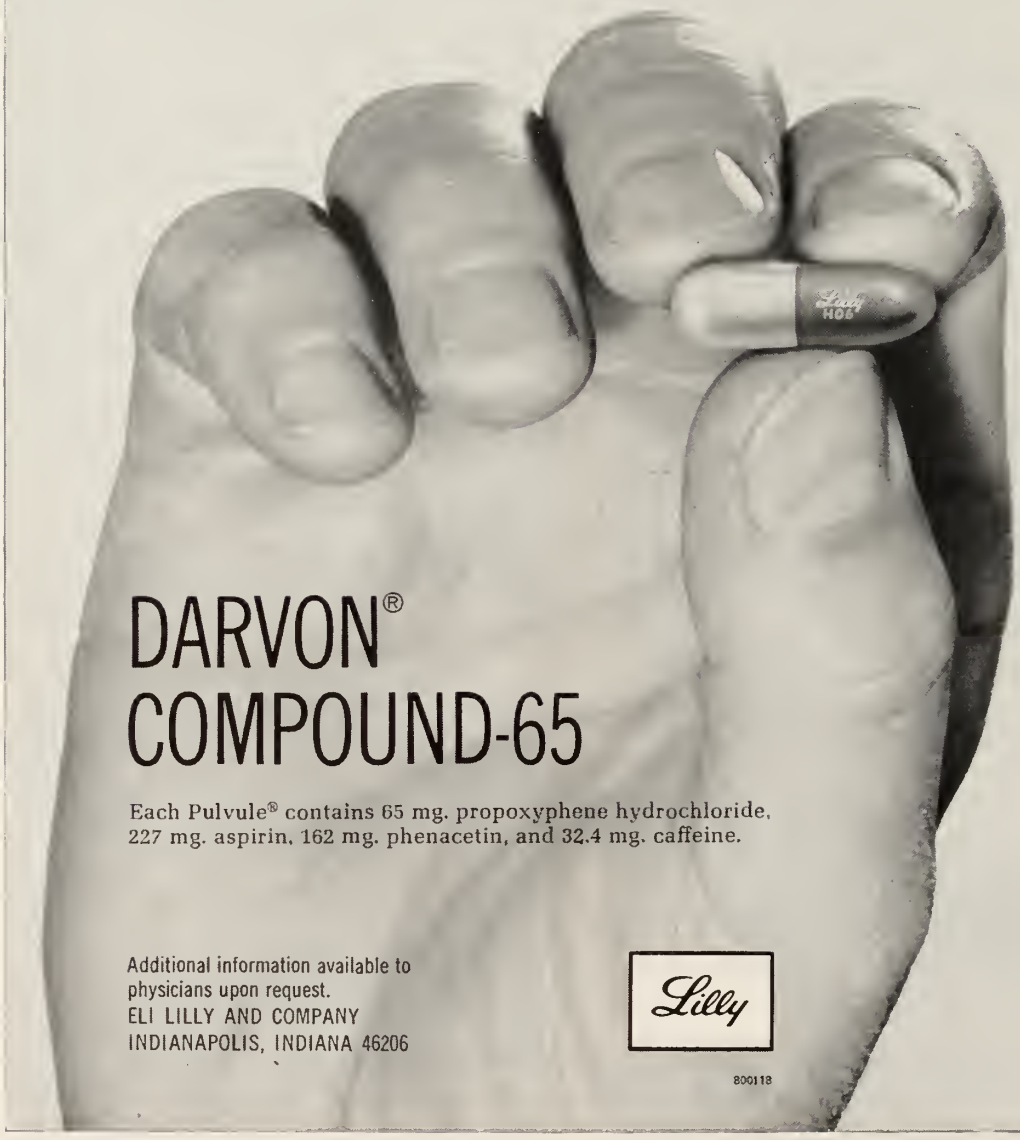
1970, April 30-May 2, Mobile

1971, April 22-24, Birmingham

1972, April 20-22, Montgomery

1973, April 18-21, Mobile

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Electrocardiographic Standards of Health: I. P Wave Duration (Lead I) In Presumably Healthy Dentists and Their Wives

By

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W. M. Ringsdorf, Jr., D. M. D., M. S.**
A. T. S. H. Setyaadmadja, M. D.***
and
R. A. Barrett, D. D. S.****

Introduction

It is generally held that the duration of the P wave [Lead I] in adults ranges from 0.070 to 0.120 seconds with a mean of 0.090 seconds and a standard deviation of 0.015 seconds [Lepeschkin, 1951]. Stewart and Manning [1944] studied the electrocardiograms of 500 Royal Canadian Air Force trainees ranging from 18 to 32 [the majority between 18 and 26 years]. The justification for regarding the group as healthy was based upon the fact that all men had passed the standard Royal Canadian Air Force medical examination for fitness for flying and had had a complete medical recheck at the time the electrocardiograms were recorded. They found the P-wave length in Lead I to be 0.080 ± 0.018 seconds. White, Parker, and Master [1944] concluded that the physiologic P_1 is 0.093 ± 0.009 seconds in 100 subjects studied principally as a routine precaution before fever therapy for the treatment of gonorrheal infections.

It is the intent of this project to determine, in a group of presumably healthy dental practitioners and their wives [members of the Southern Academy of Clinical Nutrition], the physiologic range for P_1 duration by a

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Table I
raw data

case number	age	sex	mean length P wave	CMI score	case number	age	sex	mean length P wave	CMI score
13018	33	M	0.110	12	13101	31	F	0.095	10
13019	32	F	0.080	17	13102	31	M	0.070	16
13022	37	M	0.060	10	13105	43	M	0.140	9
13025	37	F	0.080	28	13106	45	F	0.080	2
13026	32	M	0.120	47	13107	36	M	0.060	25
13034	36	M	0.055	29	13112	64	M	0.095	17
13039	41	M	0.100	21	13123	32	F	0.050	11
13044	30	M	0.080	4	13128	48	F	0.100	8
13046	39	M	0.070	6	13129	48	M	0.080	8
13047	44	F	0.100	14	13131	43	M	0.070	17
13048	47	M	0.115	20	13134	40	M	0.110	36
13051	41	M	0.110	27	13140	37	M	0.080	4
13052	38	F	0.060	13	13147	41	F	0.080	30
13059	33	M	0.110	2	13148	44	M	0.080	47
13060	32	F	0.090	4	13149	42	M	0.090	15
13062	46	M	0.075	6	13151	34	F	0.080	19
13066	50	M	0.080	5	13152	36	M	0.060	10
13067	30	F	0.080	4	13153	40	M	0.090	15
13068	37	M	0.100	5	13154	40	F	0.060	32
13073	35	M	0.070	22	13158	32	M	0.070	2
13078	43	M	0.080	5	13159	31	F	0.080	5
13083	41	F	0.060	31	13160	34	M	0.090	15
13084	38	M	0.090	14	13161	47	M	0.100	7
13085	44	M	0.055	4	13162	39	F	0.100	12
13086	40	F	0.110	14	13164	42	M	0.095	7
13099	42	F	0.040	11	13165	38	F	0.090	8
13100	41	M	0.070	14					

traditional and a nontraditional [heretofore not explored] technique.

Method of Investigation

Fifty-three dental practitioners and their wives shared in this experiment. The standard three lead electrocardiogram was recorded. The duration of the P wave was measured on two occasions by the same examiner under a dissecting microscope as previously described [Cheraskin, Ringsdorf, and Setyaadmadja, 1965]. Each subject also completed the Cornell Medical Index Health Questionnaire [Brodman, Erdman, and Wolff, 1949]. The basic data including case number, age, sex, mean length of P wave in Lead I, and CMI score are listed [Table I]. An analysis of the age pattern indicates that the major group is in the 40 to 44 year category [Table II]. The P wave duration [in seconds] ranges from a low of 0.040 to a high of 0.140 seconds with a mean of 0.084 and a standard deviation of 0.020 seconds [Table III]. An examination of the number of positive answers on the Cornell Medical Index Health Questionnaire [Table IV] reveals a spread from zero to a high of 49. The mean and standard deviation are 14.6 and 10.8 respectively.

Results

It was pointed out earlier that the general-

Table II
age distribution

age groups	number of subjects
30-34	14
35-39	13
40-44	18
45-49	6
50-54	1
60-64	1
total	53

ly recognized range for P_1 duration, on the basis of careful physical examination, is 0.090 ± 0.015. A study of the pattern in these 53 subjects discloses very similar findings [0.084 ± 0.020].

It should be recalled that each of the subjects completed the Cornell Medical Index Health Questionnaire. On the assumption that the fewer the number of positive replies, the healthier the individual, the CMI scores were arrayed and three groups defined. The first subgroup, one-third of the entire sample, was characterized by the fewest number of positive answers. Table V shows that 19 of the 53 participants had less than 9 yeses on the questionnaire. By the same categorization technique, 17 subjects had more than 16 positive answers on the CMI. It will be noted that included are those with more than 16 positive replies. On the assumption that

Table III
frequency distribution mean duration P wave [lead I]

P wave duration [seconds]	number of subjects
0.040	1
0.050	1
0.055	2
0.060	6
0.070	6
0.075	1
0.080	13
0.090	6
0.095	3
0.100	6
0.110	5
0.115	1
0.120	1
0.140	1
total	53
mean	0.084
standard deviation	0.020

Table IV
frequency distribution positive replies [CMI]

CMI scores	number of subjects
0- 4	8
5- 9	12
10-14	12
15-19	8
20-24	3
25-29	4
30-34	3
35-39	1
45-49	2
total	53
mean	14.6
standard deviation	10.8

Table V
frequency distribution mean length P wave [lead I]

mean length P wave	>16 CMI	<9 CMI
0.055	1	1
0.060	3	0
0.070	2	2
0.075	0	1
0.080	5	8
0.090	0	2
0.095	1	1
0.100	1	3
0.110	2	1
0.115	1	0
0.120	1	0
total	17	19
mean	0.084	0.084
standard deviation	0.020	0.014

Table V provides a relatively healthier and a sicker subgroup, it is appropriate to investigate the P wave duration. For the two samples, the means are the same [0.084 seconds]. However, the cluster about the mean is substantially different. Specifically, for the sickest it is 0.020 seconds; for the healthiest it is 0.014 seconds. This would tend to suggest that those with the fewest complaints are more alike with respect to this particular electrocardiographic parameter. Phrased another way, the evidence indicates that the subjects with the most complaints are characterized by relatively short or long P_1 wave duration.

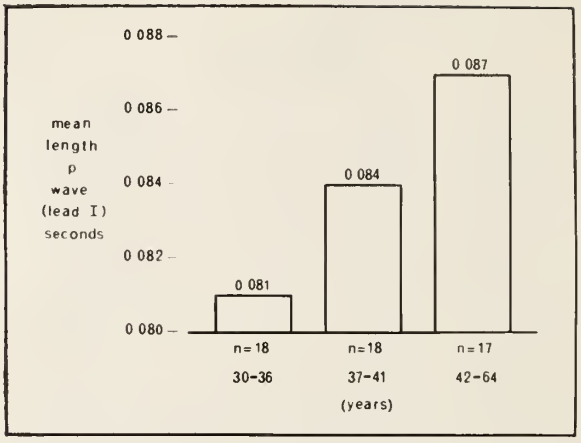


Figure 1. The relationship of age and P wave duration in Lead I. With time the P_1 length increases.

Discussion

The traditional approach to the establishment of physiologic standards is to derive the mean plus one or two standard deviations of the parameter in question from a presumably healthy sample. The presumption is that 68 to 95 per cent of such a population may be regarded as within physiologic limits. Utilizing such a conventional statistical approach, the findings in the 53 dental practitioners and their wives approach very closely the recognized norms.

There is general agreement that, with time [advancing age], P wave length slowly but inexorably increases. The fact that P wave length is longer in a majority of elderly subjects is justification enough, for some investigators, to consider the observation physiologic [Lepeschkin, 1951]. On the other hand, others hold that P wave duration does not normally lengthen with time. An attempt has been made to cast additional light on this problem.

It should be recalled that each subject completed the Cornell Medical Index Health Questionnaire [CMI]. On the assumption that the fewer the reported symptoms and signs, the healthier the individual, the sample was arrayed in near-equal subgroups on the abscissa [Figure 1] and mean length P_1 length portrayed on the ordinate. It will be noted that P_1 duration does appear to lengthen with advancing age. Thus, in the 18 subjects in the youngest age group [30-36 years] the mean length is 0.081 seconds; in the oldest [42-64 years] it is 0.087 seconds. Additionally, the groups were further subdivided on the basis of the fewer [stippled columns] and greater [black bars] number of positive CMI responses [Figure 2]. It is clear that, with time, those with the greater number of symptoms and signs show a decided progressive increase in the length of the P wave in Lead

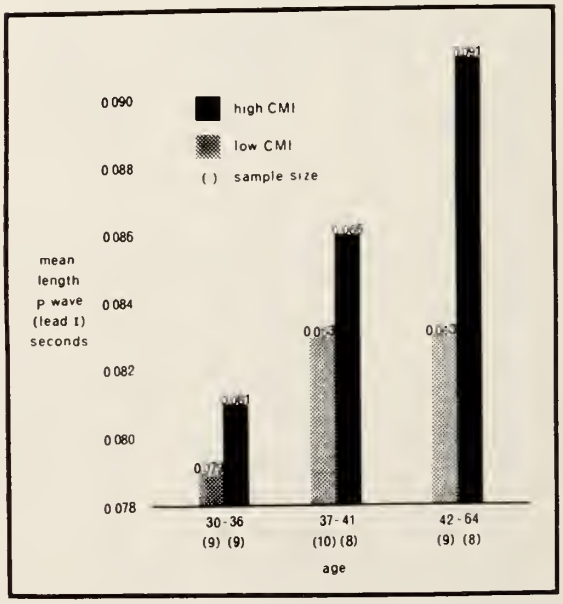


Figure 2. The relationship of age and mean length P_1 duration in terms of systemic complaints. The increase in P_1 length in the relatively healthy is slight [0.079, 0.033, and 0.083 seconds]. Conversely, in subjects with more general complaints the increment is greater [0.081, 0.086 and 0.091 seconds].

I. In the oldest age category [42-64 years] the difference is most sharply defined [0.083 versus 0.091 seconds].

Summary

1. Fifty-three presumably healthy dental practitioners and their wives participated in a study of the length of P_1.

2. By traditional statistical analysis, the findings are consistent with the recognized physiologic limits.

3. An analysis of the same data in terms of the reported presence of general symptoms and signs as reflective of early marginal illness indicates that the groups with the greater number of complaints show, with time [advancing age], a progressively longer P wave duration.

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Two Pamphlets Issued For Help to Parents

Sex education and venereal disease are just two of the topics parents hesitate to discuss with children because they feel inadequate to the task. The American Medical Association's new pamphlet, "How to Close the Parent-Child Communication Gap," describes a variety of pamphlets designed to enable parents intelligently to fulfill this educational need.

This brochure describes the AMA materials on sex education, drug abuse, venereal disease, smoking and alcohol. It contains an order blank to facilitate handling and also a "reduced rate" offer for *Today's Health.*

There are seven AMA pamphlets on teaching your children about sex and not one mentions the stork. As a guide to parents teaching their children about the dangers of alcohol, the AMA suggests three pamphlets.

To obtain copies of the brochure listing available materials, just write the AMA Circulation & Records Department.

Shaving Advice Offered In New AMA Publication

"Shaving Advice for Men," an eight-panel pamphlet produced by the AMA's Committee on Cutaneous Health and Cosmetics, is now available to the public.

Since an average man spends 3,350 hours—or 139 days—of his life ridding himself of whiskers, it stands to reason that he should be as well informed on the subject as possible. Do *you* know whether or not shaving brushes harbor enough germs to be a potential hazard, or if after-shave lotions are of any real value? Answers to these and other questions, as well as tips on shaving techniques, are included in the pamphlet, a recent addition to the Health Education Series.

Single copies may be obtained complimentarily if requests are directed to the Committee, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610. Prices for quantity orders are as follows: 50-99 copies, 14 cents each; 100-499 copies, 12 cents each; 500-999 copies, 10 cents each; 1,000 or more copies, 8 cents each. To facilitate handling, the orders should include payment and contain the code number, OP-184.

The Diagnosis and Treatment of Acute Hematogenous Osteomyelitis in Children

By

Harold E. Cannon, M. D.

Acute hematogenous osteomyelitis is predominantly a disease of childhood with almost all cases occurring in children less than twelve years of age. Prior to the introduction of antibiotics the mortality rate was 30-40 per cent but now it is less than one per cent. However, the morbidity is very high if the diagnosis is not made early and the proper treatment begun immediately. Since the child is usually not seen by an orthopedist initially, but by a pediatrician, general surgeon or general practitioner, it is very important that these physicians be thoroughly familiar with the signs and symptoms of the disease.

Acute hematogenous osteomyelitis is a distinct and separate disease from chronic osteomyelitis in several aspects and should be treated as such. It represents a septic embolus of bacteria, the primary site of which may be an abscess, furuncle, skin lesion, upper respiratory tract infection, urinary tract infection or any site that contains bacteria. In only approximately one-third of the cases is the primary source ever found.

Coagulase positive Staphylococcus aureus is the infecting organism in greater than 95 per cent of the cases. More than half of the staphylococci are resistant to penicillin. The second most common organism is hemolytic streptococcus. Rarely there may be cases caused by Escherichira coli and Aerobacter. Patients with sickle cell disease more often have Salmonella osteomyelitis. This is secondary to small ulcerations in the mucosa of the gastrointestinal tract caused by infarcts resulting from the sickle cell disease with the entrance of Salmonella into the bloodstream through these sites. Hemophilus influenza is the most common organism in children less than one year of age.

This paper was the winner of the resident's essay contest sponsored by the Alabama Chapter of the American College of Surgeons and was presented at the Annual Meeting of the Alabama Chapter at Point Clear, Alabama in February, 1968.

Pathology

There are several reasons why there is a higher incidence of hematogenous osteomyelitis in children than in adults. The primary sources of bacteria, such as furuncles, respiratory tract infections, skin lesions and others, are more prevalent in children. Also the ratio of host resistance to virulence of the organism is not as high in children as in adults. The ratio is high enough that the child may have frequent episodes of bacteremia without any resulting systemic reaction unless some factor upsets this balance to provide an opportunity for the bacteria to multiply.

The blood supply of the bones is the most important factor that must be considered in the development of acute hematogenous osteomyelitis. Each long bone of a growing child has three distinct groups of arteries. First, the epiphysis has its own blood supply separate from that of the shaft. No vessels cross the epiphyseal plate, and this is why osteomyelitis usually does not spread directly from the metaphysis to the epiphysis. However, in children less than one year of age there can be spread of the bacteria directly across the epiphyseal plate into the epiphysis and into the joint. The shaft is supplied largely by one or more nutrient arteries that enter directly through the cortex into the

medullary canal and branch up and down the canal to supply the inner two-thirds of the shaft. The outer one-third of the shaft is supplied by many small arteries coming directly from the periosteum into the outer third of the cortex. The distal femur and the proximal tibia have the most rapid rate of growth of any bones in a child and therefore have the most abundant blood supply. This is why these are the most common sites for acute hematogenous osteomyelitis. Also the metaphysis is predominantly cancellous bone, many of the vessels end there as sinusoids, and there are many end arteries. This causes a tendency for pooling of the blood and gives a bacterial embolus more of an opportunity to lodge there.

Usually the body defenses suppress any bacterial embolus that settles in the metaphysis or any other area of the bone. If for some reason the defenses are not strong enough, the bacteria may survive and begin a focus of infection. This causes the onset of an inflammatory process and the surrounding reaction causes more arteriolar thrombosis. More problems are then present because there is less blood supply to provide defense against the infection. The inflammatory exudate and pus that are produced are in a closed space inside the bone and as the pressure increases with the production of more pus, it must spread in one of three directions. The pus may spread along the intramedullary canal, through the Haversian system, or break through the Volkman canals of the cortex to the subperiosteal area. The subperiosteal pus may dissect down the shaft beneath the periosteum, may rupture through the joint capsule causing a secondary pyarthrosis, or may rupture through the periosteum into the soft tissue and may even break through the skin to produce a draining sinus to the outside.

If the pus dissects down the shaft beneath the periosteum, all the small arteries from the periosteum supplying the outer cortex of the shaft are interrupted and an avascular area of bone is produced if these are not reinstituted soon. The entire outer cortex may form a sequestrum. A localization of pus under pressure can compress the nutrient artery and cause almost the entire shaft to become avascular. Once significant areas of avascular bone are present, this heralds the onset of chronic osteomyelitis.

There is a higher incidence of acute hematogenous osteomyelitis in boys than in girls and a history of prior trauma in a significant number of cases. Some investigators think the trauma may cause enough disruption of blood supply to the local area to provide an opportunity for the onset of the infection.

Diagnosis

In the obvious cases of acute hematogenous osteomyelitis the diagnosis is easy to make. However, in a large portion of the cases the differential diagnosis may be very difficult. Yet it is very important that the diagnosis be made or highly suspected early in the course of the disease and treatment begun immediately if good results are to be obtained.

The symptoms depend on the severity of the disease. The child can present with only very mild generalized symptoms of an infection, or he can present as a very toxic child whose systemic symptoms overshadow the local symptoms. He will usually have a temperature of 102°-104°F., but this can be as high as 106°F. Generalized malaise with nausea and vomiting are very common. On the other hand local pain may be the first symptom before there are any systemic manifestations of an infection. This may be followed by swelling, erythema, warmness and tenderness of the area.

Adjacent joints are often swollen secondary to a sympathetic effusion and are painful to motion, but in acute hematogenous osteomyelitis the pain and tenderness are over the metaphysis of the bone, not directly over the joint itself. Bone tenderness is very significant and if localized is a strong indication of a subperiosteal abscess.

Laboratory findings are those of any acute

infection including an elevated white blood cell count and elevated sedimentation rate. These are non-specific and do not help significantly in the differential diagnosis, and neither do other laboratory procedures.

A roentgenographic examination of both extremities should be done anytime osteomyelitis is suspected. However, no bone changes are present on the X-ray until approximately 10-14 days after the onset of the disease and for this reason the diagnosis is often missed. The physician will think of osteomyelitis initially, but when the X-ray does not show bone changes, he assumes it is cellulitis or something else and disregards osteomyelitis. This is the source of a large portion of the diagnostic errors.

Earlier changes on X-ray include soft tissue swelling. especially in the muscle layers, but this is appreciated only by a very specialized eye. The first roentgenographic change of the bone is often a radiolucency, usually in the metaphysis. Following later is the periosteal elevation that is so often discussed.

If a definite area of tenderness is found or a subperiosteal abscess is suspected, then a needle aspiration of this should be done in an attempt to obtain pus for diagnosis and culture. It is important to remember that usually there is a sympathetic effusion of the adjacent joint with the fluid having a WBC of as high as 20,000-30,000, but rarely is there an extension of pus into the joint in children over the age of one year because it will not cross the barrier of the epiphyseal plate and subperiosteal dissection of the pus with rupture through the capsule into the joint is infrequent. Therefore the joint should not be aspirated and bacteria introduced into a previously sterile joint. The one exception to this is the hip joint where the epiphyseal plate lies inside the joint capsule and infection can spread directly from the metaphysis into the joint without going through the epiphyseal plate. This is a very common error which should be omitted. Only if a joint infection is very strongly suspected should the joint be aspirated and never "just to be sure."

The differential diagnosis of acute hematogenous osteomyelitis with several conditions that present a picture quite similar to it may be very difficult. Cellulitis provides the most frequent problem. It presents with an erythema and swelling that is more demarcated and has more induration of the skin. The fever is usually not as high and bone tenderness is not as marked as in osteomyelitis. It is much more serious to miss a case of osteomyelitis by diagnosing cellulitis than it is to treat a case of cellulitis as osteomyelitis.

Septic arthritis as a differential diagnosis has already been mentioned. The pain is directly over the joint and not over the metaphysis as in osteomyelitis. Also with a pyarthrosis there is severe pain with any active or passive motion of the joint. In osteomyelitis there can also be some pain in the bone with joint motion but usually not in the joint. It is important to state again that the adjacent joint usually has a secondary effusion in osteomyelitis but is not as tender as in a pyarthrosis.

Ewing's sarcoma can present with fever, tenderness, swelling and roentgenographic changes exactly like those of a low grade acute hematogenous osteomyelitis and often can be differentiated only by biopsy. However, Ewing's sarcoma is usually in the diaphysis while osteomyelitis is most often in the metaphysis.

There are several other conditions, including scurvy, Caffey's disease and hypervitaminosis A that can present similar to osteomyelitis but this would require a more extensive discussion.

It can be stated that the presence of septicemia, fever and other systemic signs of infection, accompanied by local tenderness over a bone, with or without swelling or redness, should be considered to be acute hematogenous osteomyelitis until proven otherwise and should be treated as such.

Treatment

The key to good results in acute hematogenous osteomyelitis is early treatment. 70-80 per cent of those in whom treatment is begun within 24-48 hours after onset of symptoms have a complete cure with antibiotics alone. It is those in whom treatment was begun after 48 hours that develop complications or require surgical drainage.

Because the diagnosis of acute hematogenous osteomyelitis is often difficult or unsure, one cannot wait for the definite diagnosis but must begin treatment immediately if it is clinically suspected. By doing this, the process may be arrested before it progresses enough to cause roentgenographic changes, so the definite diagnosis may never be made in a well treated case.

Treatment should be instituted as soon as the diagnosis is suspected, but first several studies should be done that may later help make the definite diagnosis. If there is any area of localized bone tenderness, this should be aspirated in an attempt to obtain pus for bacterial smear, culture and antibiotic sensitivities. However, if no pus can be obtained but the diagnosis is still suspected clinically, treatment must be carried out. At least three or more blood cultures should be drawn either at different times or from different sites. Any skin lesion must be cultured. Nasopharyngeal cultures should be obtained in young children. All of this must be done before antibiotic therapy is begun in order to obtain growth of the cultures.

Antibiotic and supportive therapy should be begun as soon as the above is completed. As has already been stated, over 95 per cent of the cases of acute hematogenous osteomyelitis are caused by Staphylococcus aureus so it can normally be assumed this is the organism and it should be treated as such unless the bacterial stain or something else indicates otherwise. Since in most series more than half of the Staphylococcus aureus produces penicillinase, initial treatment must include drugs for both penicillin sensitive and penicillin resistant Staphylococci. At the present time, either of two combinations of drugs may be used. Penicillin plus either oxacillin (Prostaphilin) or methcillin (Staphcillin) may be given. If only one drug is preferred, nafcillin (Unipen) alone may be given because it is bacteriocidal to both penicillin sensitive and penicillin resistant Staphylococci.

The antibiotics should be given intravenously for at least the first five days or even longer if necessary until the child is over the acute phase and has been afebrile at least 72 hours. The dosage depends on the age and size of the child. Initially, in a normal size twelve year old child, 10-20 million units of aqueous penicillin daily and 4-8 grams of either methcillin, oxacillin or nafcillin daily should be given. It should be mentioned that the synthetic penicillins deteriorate rapidly if left in a bottle of fluids, so they must be given either by direct intravenous push or in a very rapid drip within a few minutes.

After the acute stage is over, the antibiotics may be given orally. Approximately 800,000 units of oral penicillin and 0.5 grams of oxacillin should be given every six hours, or nafcillin, 0.5 grams. After the bacterial cultures and sensitivities are obtained, a change to the specific antibiotic may be indicated. Even if the sensitivities report a penicillin resistant Staphylococcus and if oxacillin or methcillin is being used, the penicillin should always be continued because a portion of the organisms may be sensitive to penicillin. Also the in vivo and in vitro sensitivities are not always the same.

The use of antibiotics in less than the optimum amount is a very common and serious error. The infection may be suppressed but not eradicated and continue as a low grade process until the stage of chronic osteomyelitis is reached. This often happens when a diagnosis of some condition other than osteomyelitis is made. If initially there were any indications at all of osteomyelitis, a repeat roentgenographic examination should

always be made in 10-14 days even if the patient appears cured.

Polycillin (Ampicillin) or other broad spectrum antibiotics should not be used to treat acute hematogenous osteomyelitis because these are not lethal to penicillin resistant Staphylococci. Also bacteriostatic drugs such as tetracyclines or erythromycin should never be used. Only bacteriocidal drugs should be used. In those patients with a definite history of penicillin allergy, Keflin is the antibiotic of choice.

Supportive therapy such as heat, elevation and immobilization is as important in acute osteomyelitis as it is in other infections. A splint or traction is a better form of immobilization than a cast because the cast often prevents observation of the local area.

The decision as to whether or not the osteomyelitis needs surgical drainage is very important. The first axiom in the treatment of pus is to drain it and this is applicable to osteomyelitis. Therefore, at anytime during the course of the disease that a frank abscess becomes evident, it must be drained.

If a subperiosteal abscess is present at the time the patient is initially seen, antibiotics are begun and then the abscess is drained. It has been shown conclusively that massive and prolonged use of antibiotics will not sterilize a subperiosteal abscess. Localized bone tenderness is a strong indication of a subperiosteal abscess. A needle aspiration should be done of any suspected area and if pus is obtained, it should be drained.

If the needle aspiration is negative or there is not indication of an abscess, antibiotics should be begun and then the clinical course will determine whether or not drainage is indicated. In following the clinical course, both the systemic and local symptoms must be closely observed. If both of these improve in the first 24-36 hours after treatment is begun, continuing the same program is indicated and surgical drainage is not indicated. If at 24-36 hours either the systemic or local symptoms are worse, regardless of how the other is doing, then surgical drainage is indicated. Almost all cases in which antibiotics are begun within the first 48 hours after the onset of symptoms can be successfully treated conservatively and will not require surgical drainage.

Surgical drainage should be done at the site where pus was aspirated and if pus was not obtained on attempt at aspiration, then drainage should be done at the site of maximum bone tenderness. If on surgically exposing the bone a subperiosteal abscess is seen, this should be drained and then several exploratory drill holes should be made in the bone to detect any pus in the intramedullary canal. If no subperiosteal abscess is present, then several exploratory drill holes should be made along the shaft until the pus is localized. In either case, if pus is found in the intramedullary canal, a window of bone should be cut out and the intramedullary canal debrided and washed clean. If pus is not obtained at all, then either the diagnosis or the location of the infection must be reconsidered.

Tight closure of the wounds around constant infusion tubes has been very successful. The ends of the tubes are placed either subperiosteally or inside the intramedullary canal, depending on where the pus was found. Normal saline containing the proper antibiotic and sometimes a detergent constantly flows through the area, the infusion is continued until the outflow solution is clear and free of debris and three negative cultures are obtained from the outflow. This usually requires ten days to two weeks.

There is no definite agreement as to how long systemic antibiotics should be continued after the local and systemic symptoms have returned to normal. Some physicians continue antibiotics for three weeks after the patient is afebrile, others for six weeks. Some use the sedimentation rate as an index and continue antibiotics until it returns to normal. All agree that antibiotics should be given four to six weeks at the minimum.

The roentgenographic examination cannot

be used as an index of how long to continue therapy because the X-ray changes of healing lag behind the clinical course just as the initial X-ray changes lagged at the onset of the disease.

Conclusion

As previously stated, 70-80 per cent of those in whom treatment is begun within the first 24-48 hours after the onset of symptoms are cured without any complications. The mortality rate is approximately 1-2 per cent.

However, the morbidity is high in those in whom treatment is instituted late. Hyperpyrexia is not uncommon and can cause permanent brain damage. Pyarthrosis of an adjacent joint by subperiosteal extension and metastatic abscesses to other portions of the body are occasionally seen. A low grade infection may result in a Brodie's abscess which may persist for decades.

Draining sinuses may develop and these are very difficult to cure. Recurrent draining sinuses are usually associated with the development of chronic osteomyelitis which is a severe complication and will not be discussed in this paper.

Fractures can result through the site of osteomyelitis and healing is very poor. Often delayed union or non-union results and frequently amputation must be resorted to in non-union of a bone with osteomyelitis.

There are other complications that are less frequent but all have a poor prognosis. This is why early diagnosis with prompt and adequate treatment of acute hematogenous osteomyelitis is of utmost importance.

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Teen-ager and Smoking Subject of Pamphlet

As an instructive, cautionary aid to parents, the American Medical Association has published a new pamphlet, "Your Teen-ager and Smoking."

Geared to the parents of teen-agers, the pamphlet provides data on the effect of cigarettes on a smoker's health. It also provides reasons and conclusions why children should not smoke.

A U. S. Public Health Service study, the pamphlet states, concluded that: 1. The teen-age smoker has a much greater chance of dying from lung cancer, chronic bronchitis, emphysema, or coronary heart failure than the smoker who starts later in life, or the non-smoker. 2. The earlier a person starts cigarette smoking, the greater the chances are that he will become a heavy smoker. According to the study, the longer a child puts off smoking, or the sooner he can break the habit, the greater are his chances of avoiding such a fate.

Your Witness—But Not For Long

By

Claude L. Brown, M. D.

Mobile, Alabama

I admit it straight out: I am a palpitating, credulous creature. A courtroom inspires visions of sinister maneuverings, unspeakable intrigue. A subpoena falls on my desk—it is as if I had caught an inadvertent glimpse of the headsman's axe. Even when the cross-examiner doesn't leave me gasping, the jury doesn't believe me. I enter a courtroom with all the *savoir faire* of a Christian gamboling into the Coliseum; I step up to the witness stand with the transfixed stare of a man gaping at his own gibbet.

Recently I testified for the defense in a murder trial where the defendant was indubitably psychotic. There was no question about it—a massive amount of evidence substantiated my diagnosis, with not even a differing opinion from the prosecution's witness. A clear-cut, black and white case (and that's a rarity). Yet the jury found the defendant sane and competent, guilty as charged, and sentenced him to death. (Justice triumphed later: The state Supreme Court reversed the decision, and without a new trial sent him to a state hospital). From such grinding experiences I have developed a viewpoint, a working path-of-approach, that has been helpful to me and that has (I hope) made my testimony more effective.

The millennium has not yet been reached in which medical witnesses will appear only as friends of the court, to give impartial testimony. True, progress is being made in some areas: medico legal panels of experts, court-appointed examiners, and other procedural improvements that we, as doctors, heartily endorse. But I regretfully suppose that the medical witness is going to be cross-examined for some time to come. Therefore, let us be prepared.

Probably a cynic said that 'the law is that which is forcefully asserted and plausibly maintained'; the law certainly is more profound and honorable than this epigram indicates. Since a trial is an adversary proceeding, however, it is difficult for a doctor to comprehend adequately his role in court. He is out of his element, unfamiliar with the house rules, barely speaking the same language, and only partially pursuing the same goals as do the lawyers.

Excellent advice is available concerning the attitude of the expert witness. In brief, this advice suggests that the doctor be modest, honest, well-informed. He should not be an advocate of either side; he should present an objective picture, and possible explanation, of the medical facts and give his opinion about these. Be intelligent, be a goodly man, and say the truth as you see it. This is absolutely sound advice. But like most advice, it doesn't work with such logical simplicity. You can be honest (even this is relative, for aside from the few doctors who consciously prostitute ethics in their testimony, we are all *unconsciously* biased in some degree), well-prepared, even articulate —and yet leave the witness stand with the uneasy feeling that you have had your foot in your mouth.

How do you remedy this situation? Here are several measures that seem to help.

I. You must be an advocate.

Not an advocate of either side. Not a truly partisan witness. But an advocate of *your own views.* I submit to you (in the lawyers' suave phrase) that the expert witness who does not ardently expound *his own*

studied opinion sadly weakens his attesting. Why so?

Because both sides want you to do that which you usually cannot; i.e., by the nature of the adversary proceeding each side builds a case *in extremo*, and then wants you to corroborate the picture as *they* have portrayed it. You, however, are not in the same role as the lawyers; you are thus not able (except in the unusual case) to wholeheartedly support *either* stand. Usually your opinion lies somewhere between, but favoring toward, one of the extremes being presented. Your opinion, then, is not entirely welcomed by one side, and is even less gladdening to the other. And you know what happens to the guy in the middle.

The burden is immediately thrust upon you to keep your testimony exactly where *you* want it to remain. Strong forces will attempt to dislodge you. For example, there is often some room for doubt. The lawyer, like you, knows that medical questions are answered differently by different honest doctors. He knows, too, that ultimate truth, being exclusively possessed by no single individual, is rather elusive. So the instant this chink of doubt appears in the armor of your opinion the point is pressed:

"You say, Doctor, that you *think* the blow on the left frontal area has some relation to the convulsions she now has? You cannot say, as a matter of absolute certainty, that this is the case, and that no o*ther* possibility exists?"

Well, there you are. The expert witness, tugged back and forth, conceding a little here, a bit there; modifying this statement, adding to that one; being led into different blind alleys and occasionally being trapped there—all this is anxiety-provoking. One is apt to become harassed, his self-confidence evaporating from his sweaty palms. Do not lose sight of your major thesis. Because if you do vacillate then you inevitably will be pulled and pushed by both sides, your views dissected and trampled into final incoherence. And you will be frustrated, the jury confused, and your function as a witness impaired. Even the most comprehensive conclusions can be vitiated unless they are clung to through the smoke and thunder of the verbal artillery duels. With a clear eye on the necessity of saying your piece forcefully, let's plan how you may better do just this.

II. Gamemanship under the gavel (or, nautically, tacking and jibbing before the bar).

A. Matters to be observed, handled properly, and then ignored.

1. Your credentials—don't be misled either into grandiosity or servility by your credentials or lack of them. Unless you're just a triple-distilled knockout, I don't believe that the average jury cares whether you're Dr. Renfrow Glutz or Sir William Osler. You're a doctor, and your manner and what you say is all-important—not *who* you are, (Obviously, I assume that you are testifying about a subject that is commonly considered to be within your realm of competence).

2. Your integrity—this is handled by gently asking if you have been paid to examine the patient; if you are going to be paid for your court appearance; who is going to pay you; how much you are going to charge, whether you have discussed the case with a lawyer.

Answer all such questions promptly and cheerfully. The examiner is merely leading you through the paces, seeing which way you shy. A word about fees: there are several satisfactory methods of calculating a fee for examinations, reports, testimony—have a clear method in mind for figuring your fee. The occasional overcharging 'because of the nuisance involved' seems dubious to me; if you decide to charge thusly, it's a poor idea to state in court such a justification of a fee. But by all means answer such questions about money openly and without hesitation, not with the pained air of a man caught dipping into the church collection plate.

3. Histrionics and stage work by the examiner—table pounding, sarcasm, pacing and gesticulating, being 'sweetly reasonable', referring in silence to ominous piles of books on his table (You think these are medical books from which your statements are going to be triumphantly contradicted. This *may* be true, but most of those books are esoteric tomes filled with rulings of the Appellate Court of Hardrock County).

B. Items not to be ignored

1. Your demeanor—always be courteous and succinct; never be sarcastic or jocular, nor pontifical nor superficial. One should never quarrel emotionally nor argue intellectually with the examiner. Regardless of good cause for such responses, they can only damage the picture you want to portray: a non-partisan, informed medical witness. Keep it cool and calm.

2. Notes and books—use notes 'to refresh your memory', and don't simply read them. If you value a book, don't loan it to a lawyer (even a dear friend) and don't bring it to court.

3. Sincerity of the person you examined. This a favorite question, and it's loaded. In general, unless you are *convinced* that the person is deliberately malingering (and are thoroughly prepared to explain this conviction) it is best to indicate that you consider the individual sincere in his complaints. You can always qualify and explain this in many ways. Usually the *'opposing'* lawyer wants you to say that you doubt the sincerity of the person, because counsel knows that saying this makes you vulnerable to attack, and also makes you look like a suspicious, cold character. A bad impression, that you do not wish to create without strong reasons.

4. The examiner's demand that you answer questions in *his* terms. It is highly important to disregard this demand. *Within reason, you can answer just as you please.* But remember: no lectures, no digressions, no arguing with the examiner—The court is tired of sitting still, the docket is long, *tempus fugit.* Stick to the point, but say whatever you want to say. Often the examiner may stop you, but judges are most benevolent in allowing witnesses to express themselves. If you keep emphasizing your beliefs, the examiner usually will climb off your back. He doesn't want to give you a forum for your opinions, if they are opposed to the case he is trying to make.

Lawyers make a tremendous play on the words 'probable', 'possible', and other terms involving the relativity of cause and effect. Such preoccupations with the niceties of language are gambits to entice a more definite statement from the witness. Very often I don't have an absolutely conclusive opinion; the best I can say is 'probably'. But I'm not embarrassed by my lack of omniscience. I say 'probably' as forcefully as I can and I keep on saying just that.

A well-charted tactic of cross-examination (particularly in the examination of psychiatrists, but it can apply to other doctors) goes like this:

Q. Now, doctor, your findings are based primarily on what the patient *told* you about himself—isn't that true?

A. Well . . . partially true.

This answer piques curiosity. The next question always is:

Q. On what else, then, are your findings based?

A. What the patient tells me—not only by his words, but by his walk, his appearance, his phraseology, his behavior—is quite important, of course. But also of importance is what these items mean to me. These items are synthesized, through my *interpretation* of their meaning, into an opinion about the person. (You can draw analogies if you wish: the patient furnishes the data, you do the interpretation of the data, etc.)

Q. What do you mean, your interpretation?

This question opens the door for me (which is what I've been aiming at) for an elabora-

tion of the nature of a mental status examination. I now have an opportunity to emphasize, in substantiating detail, the derivation and meaning of my opinion. About half way through such a recital the examiner realizes that I am heaping Ossa upon Pelion (never use a sententious phrase like that in court) and halts the discourse.

In summary: Entering into the spirit of the thing can be not only intellectually stimulating, but can, I am convinced, lead to more effective testimony. Testimony that is essentially *yours*, not t e s t i m o n y that is strangled, chipped and distorted into a caricature of your real meaning. One must *study* the case thoroughly, be aware of inconsistencies and doubtful areas, recognize points of vulnerability and be prepared for attacks there. Be as well-informed as you can, conduct yourself appropriately, and stick to *your* story and *your* opinion—after all, that's really why you're there: for your opinion.

Dr. James To Head Research For CVRT Program

Dr. Thomas N. James, an internationally renowned cardiologist, has joined the Medical College of Alabama faculty as director of research, Cardiovascular Research and Training Program. He will also serve as senior scientist in the CVRT Program and as professor in the Departments of Medicine and Pathology.

The announcement of Dr. James' appointment was made by Dr. S. Richardson Hill, Jr., dean of the Medical College and Dr. T. Joseph Reeves, director of the Cardiovascular Center, and Alabama Heart Professor of Cardiovascular Research.

Dr. James, who was chairman of the Cardiovascular Research Section at Henry Ford Hospital in Detroit, Michigan, assumed his new responsibilities at the Medical Center on July 1, 1968.

As director of research in the Cardiovascular Research and Training Program, Dr. James will be responsible for coordinating further developments of the Medical Center's research activities in the field of heart and blood vessel disease. The Cardiovascular Research and Training Program is a multidisciplinary program recently established at the Medical Center. It brings to bear the knowledge and skills of scientists in the fields of cardiovascular surgery, medical cardiology, pediatric cardiology, physiology, biochemistry, molecular biology, mathematics, computer science, statistics, radiology, and pathology in a coordinated attack on basic and clinical problems relating to diseases of the heart and blood vessels.

The M e d i c a l Center was awarded a $2,100,000 grant last year to begin a development of the center for research in cardiovascular diseases. It is anticipated that a total of $4,877,000 for this program will be received over a five year period.

In announcing this appointment, Dr. Hill said, "We are delighted and proud to have Dr. James join our faculty and we are confident that his leadership of the Cardiovascular Center's research efforts will provide even greater impetus to an already outstanding program—one that has brought international recognition to the Medical Center and to Birmingham. Dr. James is a scientist of extraordinary breadth who has made significant contributions to our knowledge of a variety of cardiovascular diseases. The report of his study on the anatomy and function of the coronary arteries is generally regarded throughout the world as the definitive monograph on the subject. He is equally recognized for his contributions to the understanding of the structure and function of the conduction system of the heart."

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This endeavor has been warmly endorsed by the American Nurses Association and other professional organizations. We feel sure that such a program, bringing skilled nursing care to the bedside of the cancer patient, will be enthusiastically received by the medical profession.

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Contraindications — Thrombophlebitis or a history of thrombophlebitis or pulmonary embolism, liver dysfunction or disease, known or suspected carcinoma of the breasts or genital organs and undiagnosed vaginal bleeding.

Warnings — Discontinue medication pending examination if sudden partial or complete loss of vision, or sudden onset of proptosis, diplopia or migraine occurs. Discontinue if papilledema or retinal vascular lesions occur. Since the safety of Ovulen in pregnancy has not been established, rule out pregnancy before a patient who has missed two consecutive menstrual periods continues the tablets. Consider the possibility of pregnancy at the first missed withdrawal flow if the recommended schedule has not been followed. The active ingredients in oral contraceptives have been identified in the milk of mothers receiving these drugs. The significance of this to the infant has not been determined.

Precautions — The pretreatment physical examination should specifically include the breasts, pelvic organs and a Papanicolaou smear. Endocrine and possibly liver function tests may be affected by Ovulen. Such tests should be repeated two months after stopping the medication if their results were abnormal in a woman taking Ovulen. Pre-existing fibroids may enlarge under the influence of progestin-estrogen preparations. Patients with epilepsy, migraine, asthma, cardiac or renal dysfunction, which conditions might be influenced, require careful observation because Ovulen may cause some degree of fluid retention.

Ovulen should be used with caution in patients with a history of cerebrovascular accident. Nonfunctional causes should be considered if breakthrough bleeding occurs. Adequate diagnostic measures are indicated in women with undiagnosed vaginal bleeding. Carefully observe patients with a history of psychic depression and discontinue the medication if depression recurs to a serious degree. Any possible influence of prolonged Ovulen use on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. Carefully observe diabetic patients during Ovulen use since a decrease in glucose tolerance has occurred in a few such patients. Physicians should be alert to the earliest manifestations of thrombophlebitis and pulmonary embolism since such conditions occasionally occur in patients taking oral contraceptives. Use Ovulen judiciously in young patients in whom bone growth is not complete because of the effects of estrogens on epiphyseal closure. Age is no absolute limiting factor, although Ovulen use may mask the onset of the climacteric. Pathologists should be informed of Ovulen use when relevant specimens are submitted.

Side effects — The following adverse reactions have been observed in varying incidence in patients taking oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea, edema, chloasma or melasma, breast changes (tenderness, enlargement, secretion), change in weight (increase or decrease), changes in cervical erosions and secretions, suppression of lactation when used immediately post partum, cholestatic jaundice, migraine, allergic rash, rise in blood pressure in susceptible individuals and mental depression.

Although the following side effects have been reported in users of oral contraceptives no cause and effect relationship has been established: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme and nodosum, hemorrhagic eruption and itching. Thrombophlebitis, pulmonary embolism and neuro-ocular lesions have occurred in users of oral contraceptives, although a cause and effect relationship has been neither established nor disproved.

The following laboratory results may be altered by oral contraceptives: Bromsulphalein® and other hepatic function tests—increased; coagulation tests, including prothrombin, Factors VII, VIII, IX and X — increased; thyroid function — increase in protein-bound iodine and butanol extractable protein-bound iodine, and a decrease in T^3 values; metyrapone test and pregnanediol determinations.

Dosage and administration — One tablet of Ovulen-21 daily for 21 consecutive days, beginning five days after the onset of menstrual flow (the first day of menstruation is counted as day 1), then discontinued for one week. If Ovulen is started later than day 5 after menses begins another method of protection is used until the first seven tablets have been taken. Subsequent 21-day courses are begun on the eighth day after the last tablet was taken in the preceding cycle. This three weeks on — one week off schedule is continued whether or not withdrawal flow has begun, flow has ceased or spotting or breakthrough bleeding has been experienced.

If one tablet is missed it is to be taken as soon as it is remembered and the next tablet at the usual time. If two consecutive tablets are missed the dosage is doubled for the next two days, then the regular schedule is resumed. If three consecutive tablets are missed a new tablet cycle is started on the eighth day after the last tablet was taken. For the best protection in the latter two instances instruct the patient to use another method of contraception until the next seven consecutive tablets have been taken. The possibility of ovulation increases with each successive tablet missed.

Postpartum administration — Non-nursing mothers may begin Ovulen immediately after delivery and nursing mothers after lactation is well established.

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Before prescribing or administering, see Sandoz literature for full product information, including adverse reactions reported with phenothiazines. The following is a brief precautionary statement.

Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.

Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when necessary.

Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving). Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascular System*—Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers, including Mellaril (thioridazine hydrochloride). While there is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients previously showing electrocardiographic changes. The use of periodic electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. *Other*—A single case described as parotid swelling.

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25 mg. t.i.d.

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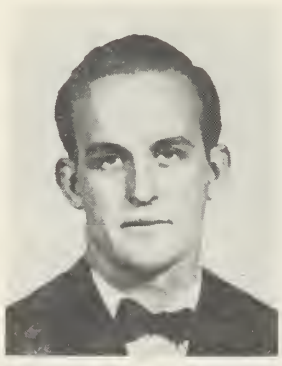
Thomas Henry Alphin, M. D., University of Virginia School of Medicine, 1947, Reciprocity with Virginia—Located in Montgomery.

Ralph Michael diCosola, M. D., University of Illinois College of Medicine, 1927, Reciprocity with Illinois—Intends to locate in Anniston.



Charles Arthur Bush, M. D., Western Reserve University School of Medicine, 1965, Reciprocity with Ohio—Intends to locate in Montgomery (Maxwell AFB).





Lamar Lafayette Fleming, M. D., Medical College of Georgia, 1965, Reciprocity with Georgia —Intends to locate (Pensacola, Fla—US Navy).



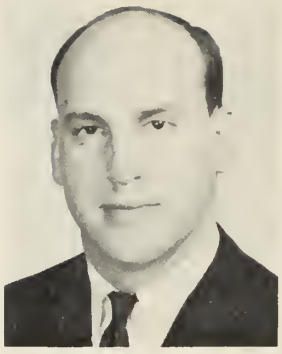
Joe Thomas Downard, M. D., University of Mississippi School of Medicine, 1958, Reciprocity with Mississippi—Intends to locate in Selma.

Maureen Alice Harman, M. D., Seton Hall (Now New Jersey) College of Medicine, 1963, Reciprocity with National Board of Medical Examiners—Intends to locate in Birmingham.





Gerald David Landau, M. D., State University of N. Y. Upstate Medical Center, 1957, Reciprocity with National Board of Medical Examiners—Intends to locate in Enterprise (Fort Rucker).



Lionel Z. Naylor, M. D., Louisiana State University School of Medicine, 1963, Reciprocity with Louisiana—Intends to locate in Decatur.



Billy Sam Moore, M. D., Vanderbilt University School of Medicine, 1963, Reciprocity with National Board of Medical Examiners—Intends to locate in Huntsville.



Edwin Stanley Wilson, Jr., M. D., Hahnemann Medical College, 1962, Reciprocity with National Board of Medical Examiners—Intends to locate in (Fort Benning —US Army).



Billy Morris Wansley, M. D., University of Mississippi School of Medicine, 1960, Reciprocity with Mississippi—Intends to locate in Decatur.



Albert Oberman, M. D., Washington University School of Medicine, 1959, Reciprocity with Missouri—Intends to locate in Birmingham.

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"Where the Action Is!"

Program

Alabama Diabetes Association

Parliament House—Birmingham, Alabama

September 22, 1968

REGISTRATION: 12:00-12:45 P. M.—Parliament House Lobby

BUSINESS: 12:45-1 P. M.

INTRODUCTION OF SPEAKER BY DR. LEON SMELO

1:00- 1:45 P. M.—Dr. David M. Kipnis, Professor of Medicine, Washington University

TOPIC: "Recent Studies on Insulin Secretion"

INTRODUCTION OF SPEAKER BY DR. BURIS R. BOSHELL

1:45- 2:30 P. M.—Dr. Rubin Andres, Associate Prof. of Medicine, Johns Hopkins University

TOPIC: "Changes in Glucose Tolerance with Aging"

COFFEE BREAK: 2:30-2:45 P. M.

INTRODUCTION OF SPEAKER BY DR. ADRIAN A. CHANDLER

2:45- 3:30 P. M.—Dr. Theodore W. Lieberman, Assistant Professor of Ophthalmology, Mt. Sinai School of Medicine

TOPIC: "The Natural Course of Diabetic Retinopathy"

PANEL DISCUSSION: Dr. Arthur K. Black, Moderator

3:30- 4:15 P. M.

SPEAKERS: Doctors Kipnis, Andres, Lieberman

TOPIC: "Diagnosis and Treatment of Diabetes Mellitus"



What can be done for Susan Jane To stop the runs and crampy pain?

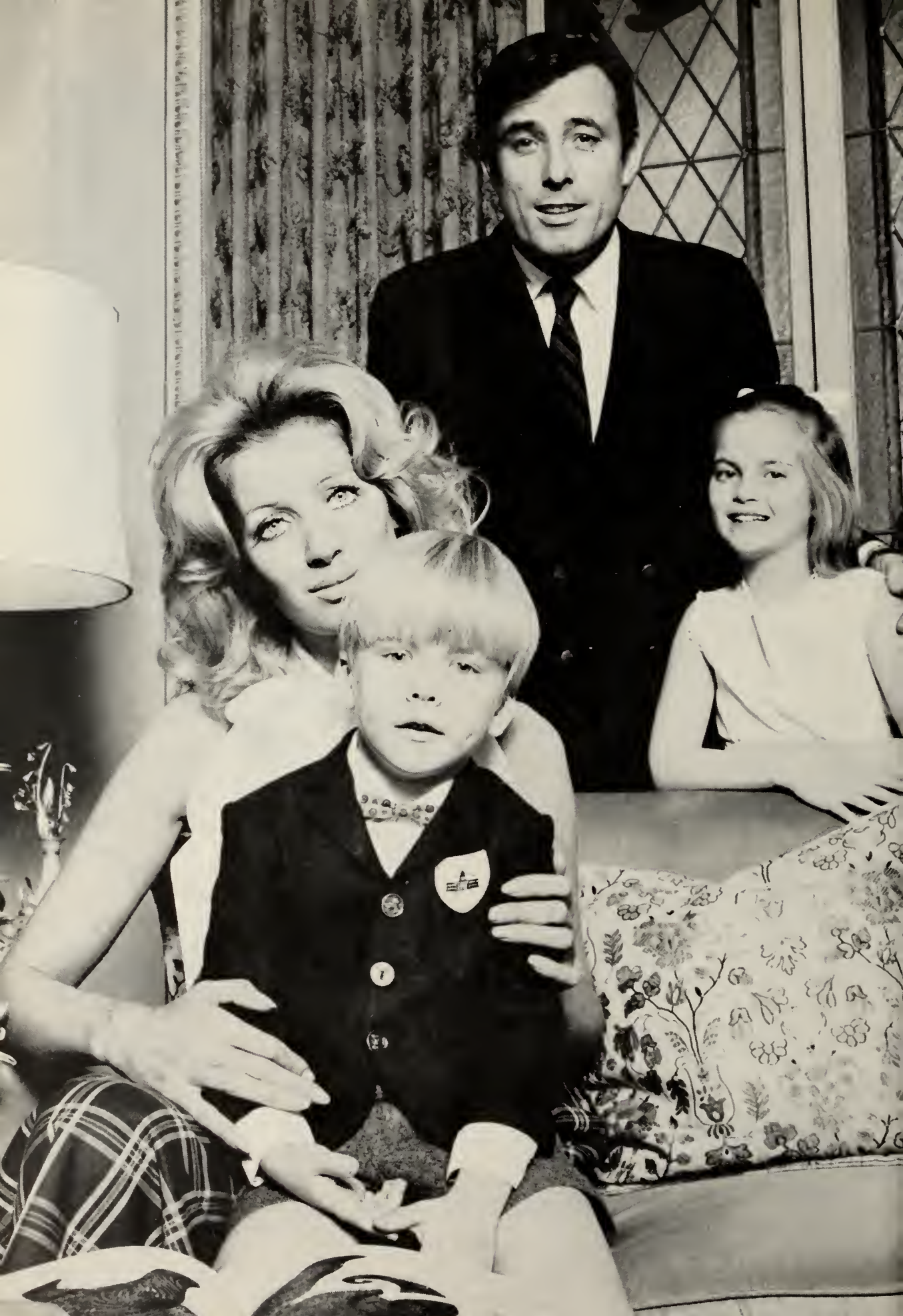
Parepectolin for quick relief of acute diarrhea
...soothes colicky pain with paregoric
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...adsorbs irritants with kaolin, and protects intestinal mucosa.

In children, Parepectolin may be used to control diarrhea promptly and prevent dehydration, until etiology has been determined. In some cases, Parepectolin may be all the therapy necessary.

Parepectolin®

Each fluid ounce of creamy white suspension contains:
Paregoric (equivalent).....(1.0 dram) 3.7 ml.
Contains opium (¼ grain) 15 mg. per fluid ounce.
warning: may be habit forming
Pectin ..... (2½ grains) 162 mg.
Kaolin (specially purified)....(85 grains) 5.5 Gm.
(alcohol 0.69%)
Usual Children's Dose: One or two teaspoonfuls three times daily.

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Fort Washington, Pa.



pinworms
n this
amily?

possibly, because hygienic measures alone, however meticulous, may not prevent the spread of pinworm infections

REMINDER: Because pinworm infections spread easily and quickly in families, schools, and institutions, multiple infections in primary groups seem to be the rule rather than the exception. For successful management, it is desirable to check all exposed members of the family or play group. The *single-dose efficacy* of POVAN makes group therapy entirely practical, convenient, and economical.

INDICATION: Pinworm infection.

PRECAUTIONS: Tablets should be swallowed whole to avoid staining teeth. Pyrvinium pamoate will stain most materials. Stools may be colored red.

ADVERSE REACTIONS: Nausea, vomiting, cramping, and diarrhea have been reported.

POVAN is available in suspension or tablet form. The pleasant-tasting, strawberry-flavored suspension contains the pamoate equivalent of 10 mg. of pyrvinium base per cc., in 2-oz. bottles. The sugar-coated tablets each contain the pamoate equivalent of 50 mg. of pyrvinium base, bottles of 25.

...and if hygienic measures alone are not enough...?

when examination reveals pinworm infection, estimated to occur in from ⅓ to more than ½ of all American children from every social level, an increasing number of physicians favor treatment with a single, economical dose of—

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Vital Statistics

NEW MEMBERS

Jefferson County

Corssen, Guenter, 619 S. 19th St., Birmingham, Ala. 35233. (822-7419)

Rowe, Luther Conrad, 2124 4th Ave. S., Birmingham, Ala. 35233. (323-1661)

Shaw, June Fore, 619 19th St. S., Birmingham, Ala. 35233. (822-4720)

Montgomery County

Spada, Frank Joseph, 2119 E. South Blvd., Montgomery, Ala. 36111. (288-4895)

Underwood, Samuel Jefferson, 1031 Oak St., Montgomery, Ala. 36108. (Transferred from nonmember.) (265-6942)

Morgan County

Hawkins, Rowland Dale, Block-Chandler Clinic, Highway 31, North, Hartselle, Ala. 35640. (773-2503)

DEATHS

Jefferson County

Upchurch, Samuel Earl, 901 South 17th Street, Birmingham, Ala. 35205—deceased June, 1968.

CHANGES OF ADDRESSES OF MEMBERS

DeKalb County

Walker, James A., present Birmingham, Ala. 35223, to 2042 Forrest Ave., North, Fort Payne, Ala. 35967.

Etowah County

Anderson, William O., present Gadsden, Ala. 35901, to 303 Bay St., Gadsden, Ala. 35901.

Cross, John T., present Gadsden, Ala. 35901, to 303 Bay St., Gadsden, Ala. 35901.

Denson, Joe W., present Gadsden, Ala. 35901, to 303 Bay St., Gadsden, Ala. 35901.

Dozier, Slater M., present Gadsden, Ala. 35901, to 303 Bay St., Gadsden, Ala. 35901.

Gowaty, Henry F. J., present Gadsden, Ala. 35901, to 303 Bay St., Gadsden, Ala. 35901.

Nolen, Jack R., present Gadsden, Ala. 35901, to 303 Bay St., Gadsden, Ala. 35901.

Odom, Corley W., present Gadsden, Ala. 35901, to 303 Bay St., Gadsden, Ala. 35901.

Rowe, Stephen W., present Gadsden, Ala. 35901, to 303 Bay St., Gadsden, Ala. 35901.

Steinberg, Benjamin J., present Gadsden, Ala. 35901, to 303 Bay St., Gadsden, Ala. 35901.

Steinberg, Morris, present Gadsden, Ala. 35901, to 303 Bay St., Gadsden, Ala. 35901.

Warren, William S., Gadsden, Ala. 35901, to 315 S. 4th St., Gadsden, Ala. 35901.

Jefferson County

Compton, M. E., Jr., present Birmingham, Ala. 35203, to 708 Castlewood Dr., Bessemer, Ala. 35020.

Cooley, Beamon S., Sr., present Birmingham, Ala. 35203, to 1322 N. 31st St., Birmingham, Ala. 35234.

Dodson, William H., present Birmingham, Ala. 35233, to Medical Arts Bldg., Birmingham, Ala. 35205.

Nunis, Jimmy B., present Birmingham, Ala. 35233, to 1529 North 25th St., Birmingham, Ala. 35204.

Patton, Francis M., present Fairfield, Ala. 35064, to 1136 Iredell Circle, Birmingham, Ala. 35209.

Sox, Joe H., present Pinson, Ala. 35126, to 3164 Cahaba Heights Plaza, Birmingham, Ala. 35243.

Zenger, George H., present Birmingham, Ala. 35217, to 1025 S. 18th St., Birmingham, Ala. 35205.

Lauderdale County

Reagan, Jack E., present Florence, Ala. 35630, to 409 Noojin Bldg., Gadsden, Ala. 35901.

Madison County

Browning, Russell L., present San Francisco, Calif. 96269, to 1017 W. Carson St., Greenville, Tenn. 37743.

Mobile County

Lyden, John A., Jr., present Mobile, Ala. 36604, to 182 Louiselle St., Mobile, Ala. 36607.

TRANSFER MEMBER

Clarke County

Bowling, Robert Shaw, Jr., P. O. Box 428, Jackson, Ala. 36545. (Transfer from member of Clarke County Medical Society to nonmember in Clarke County.)

MISCELLANEOUS

Houston County

Change of type of practice for Dr. Rube Roland Hundley from General Practice to Urology.

Tuscaloosa County

Change of type of practice for Dr. James C. Folsom, from General Practice-Surgery to Psychiatry.

County Society Meetings

Bullock County

Bullock County Medical Society held a business meeting in June at the Bullock County Hospital. Four members were present. Vice-President, J. K. Haygood, M. D., presided.

Conecuh County

Dr. Larry Hatch, pathologist of Montgomery, was the principal speaker at the June meeting of the Conecuh County Medical Society. His subject was "Standards and Procedures in a Clinical Hospital Laboratory."

Dr. R. W. Stallworth, president, presided, four members were present.

Dallas County

Mr. Frank Chappelle discussed "The Keogh Plan" at the regular meeting of the Dallas County Medical Society. The meeting was held at the BPOE Lodge with 30 members present. Dr. G. C. Noah, Jr., presided.

A report from Blue Cross-Blue Shield was discussed during the business session.

DeKalb County

"The Measurement of Depression," a movie, was shown at the June meeting of the DeKalb County Medical Society. The meeting was held at the DeKalb General Hospital with Dr. William C. Gibson, president, presiding. Seven members were present.

Winston County

Mr. Al Johnson of Blue Cross-Blue Shield was principal speaker for the June meeting of the Winston County Medical Society. His subject was "Some Upcoming Changes in Blue Cross in Alabama."

There was also a discussion of Head Start in Winston County during the business session.

Four of five members were present, there were three Dentists as guests. Dr. Ben Moore, president, presided.

Tuberculosis? Influenza?
Pneumonia? Leukemia?
Hodgkin's Disease? Syphilis?
Systemic Fungal Diseases?
Chronic Chest Diseases?
or
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PROGRAM

Second Alabama Rural Health Conference

Sponsored by

Medical Association of the State of Alabama

In Cooperation with Rural Health Council of Alabama

Wednesday, August 21, 1968, Jefferson Davis Hotel

Montgomery, Alabama

8:30 A. M.

Registration

Morning Session

9:45 A. M.



Call to Order

Presiding

Winston A. Edwards, M. D., Chairman, Committee on Rural Health, Medical Association of the State of Alabama, Wetumpka, Alabama



Invocation

The Reverend Henry L. Lyon, Jr., Pastor, Highland Avenue Baptist Church, Montgomery, Alabama



Introductory Remarks

Welcome

The Honorable Earl James, Mayor, City of Montgomery



E. L. McCafferty, Jr., M. D., President, Medical Association of the State of Alabama, Mobile, Alabama



Address—The Honorable Albert P. Brewer, Governor, State of Alabama

10:05 A. M.

AMA's Rural Emergency Care Plan



Bond L. Bible, PhD., Secretary, Council on Rural Health, American Medical Association, Chicago, Illinois

10:35 A. M.

Health Manpower



Joseph F. Volker, D. D. S., PhD., Executive Vice-President, University of Alabama in Birmingham

11:00 A. M.

Smoking and Health



George F. Scofield, M. D., Pathologist, Carraway Methodist Hospital, Birmingham, Alabama

LUNCHEON

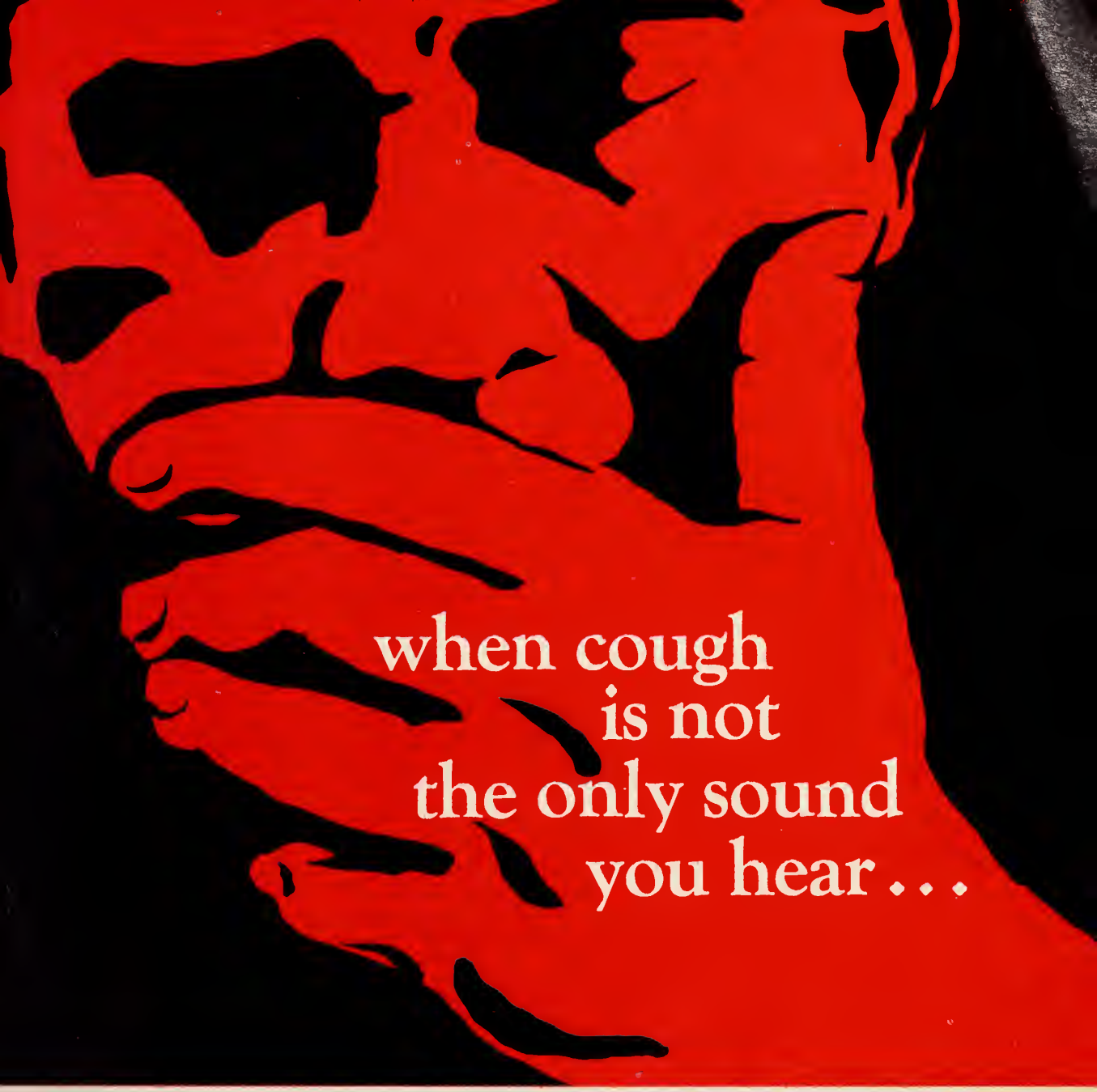
12 Noon

Presiding, Winston A. Edwards, M. D.

Invocation, The Reverend Henry L. Lyon, Jr.

Introduction of Guest Speaker, Paul Nickerson, M. D., Sylacauga, Alabama

(Continued on Page 146)



OMNI-TUSS® b.i.d.

. . . **because** OMNI-TUSS is indicated for cough associated with upper respiratory tract infections, bronchitis, bronchiectasis, bronchial asthma, emphysema, sinusitis and rhinitis, hay fever, or other allergic conditions. Any of these conditions may exhibit the general symptom syndrome—coughing, wheezing, bronchospasm, and tenacious mucus—which may benefit from the antitussive, bronchodilative, antihistaminic, and expectorant action of Omni-Tuss.

The therapeutic usefulness of Omni-Tuss is enhanced by a unique resin complex formulation providing the clinically desirable advantages of: (1) uniform drug availability throughout an extended period, (2) 8 to 12 hours of symptomatic control, (3) minimal dosage requirement, (4) minimal side effects.

Economical, efficient **b.i.d.** dosage—extremely well-tolerated by children, 6-12, and adults.

'Omni Tuss' Suspension: Each teaspoonful (5 cc.) contains 10 mg. codeine (Warning: May be habit-forming), 5 mg. phenyltoloxamine, 3 mg. chlorpheniramine, 25 mg. ephedrine, all as cation exchange resin complexes of sulfonated polystyrene, and 20 mg. guaiacol carbonate.

Available on prescription only. Class X exempt narcotic. Permissible on oral prescription.

Dosage: *Adults:* 1 teaspoonful (5 cc.) q12h.
Children (6-12 *years*)*:* ½ teaspoonful q12h.

Side Effects: Minimal, but when encountered may include jitteriness, nausea, drying of mouth, insomnia, constipation, which disappear upon adjustment of the dose or discontinuance of treatment.

Precautions and Contraindications: For complete detailed information, refer to package insert or official brochure.

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Wallace & Tiernan Inc., Rochester, N.Y.

12:45 P. M.

ADDRESS



W. Wyan Washburn, M. D., Past Chairman, Council on Rural Health, American Medical Association, Boiling Springs, North Carolina

Afternoon Session

2:00 P. M.

Traffic Safety



Mr. Paschal P. Vacca, Vice Chairman, State Safety Coordinating Committee, Montgomery, Alabama

2:15 P. M.

Narcotics and Drug Control



Ira L. Myers, M. D., State Health Officer, State Department of Public Health, Montgomery, Alabama

2:45 P. M.

Summation



Mr. James D. Hays, President, Alabama Farm Bureau Federation, Montgomery, Alabama

Member Organizations

Rural Health Council of Alabama

Alabama Farm Bureau Federation

Auburn University

Medical Association of the State of Alabama

Alabama Veterinary Medical Association

Alabama Dental Association

Alabama Congress of Parents and Teachers

Alabama Department of Public Health

Committee on Rural Health
Medical Association of the State of Alabama

Winston A. Edwards, M. D., Chairman, Wetumpka

John E. Haynes, M. D., Pell City

Donald S. Tysinger, Jr., M. D., Dothan

Sumner D. Davis, M. D., Talladega

Maurice F. Fitz-Gerald, M. D., Demopolis

Frank M. Phillippi, Jr., M. D., Brewton

Community Health Week To Stress Three Themes

Three timely themes—drug abuse, physical fitness and health careers—are being encouraged for development in local medical society-directed programs marking the sixth annual observance of Community Health Week, October 20-26.

Community Health Week is a public service program inaugurated by the AMA's House of Delegates in 1962.

Goals of the observance are for medical societies, in cooperation with other members of the community health team, to present meaningful programs aimed at furthering public awareness of the wide variety of health services and facilities existing at the community level, to call attention to present health problems and potential solutions, and to call attention to continuing medical advances.

The kit of programming materials for Community Health Week—1968 is now being developed. Materials contained in this comprehensive kit will be built around the three recommended themes.

Heart Hospital Planned By University

Construction of an $11 million Alabama Heart Hospital is planned at University of Alabama Medical Center within the next four years, UA officials have announced.

Fifty per cent of the hospital's cost will be financed by private donations to be solicited in a fund drive next fall, said Dr. Harold W. Schnaper, co-director of the University's Cardiovascular Research and Training Center.

"WE WILL APPLY for a federal grant to provide the other half of the cost," said Dr. Schnaper, noting with gratitude the enormous grand support the federal government has given the cardiovascular program in the past few years.

The proposed Alabama Heart Hospital would have 250-300 beds, providing urgently needed space, laboratory and teaching facilities for clinical aspects of the University's cardiovascular program.

Dr. Schnaper said plans for the fund drive are to appeal to a small group of donors rather than to the general public.

AN ADVISORY committee of some 30-75 persons and a seven-man executive committee will head the drive.

They will be selected from a list of names suggested by Alabama business and civic leaders who attended a private dinner hosted by the University at the Relay House.

Addressing those attending the dinner were Dr. Joseph F. Volker, University executive vice president for Birmingham affairs; Dr. Joseph Reeves, director of the University's Cardiovascular Research and Training Center; Dr. S. Richardson Hill, dean of the Medical College of Alabama; Dr. Harold Dodge, chairman of the division of Cardiology; Dr. John Kirklin, chairman of the department of surgery, and Dr. Tinsley Harrison, distinguished professor of medicine.

DR. SCHNAPER said the University hasn't yet decided on a location for the heart hospital.

"The hospital will possibly be located near the present University Hospital, where the Old Hillman Building now stands," he continued.

"If we proceed with plans for a University Hospital No. 2, then the hospital could be located near that hospital.

"At any rate, we want to utilize some of the facilities at an existing hospital and avoid expensive duplication."

Plans for the Alabama Heart Hospital are part of the STRIDE program announced recently by University President Frank Rose, for $400 million in expanded facilities for the University of Alabama over the next 10 years.

The University's cardiovascular program has been hailed by many authorities as one of the most promising of its type in the nation.

TENNESSEE VALLEY MEDICAL ASSEMBLY

Memorial Auditorium

Chattanooga, Tennessee

September 13-14, 1968

E. Wayne Gilley, M. D., Chairman
107 Interstate Building
Chattanooga, Tennessee 37402



Summation:
In addition to its primary indications for duodenal and gastric ulcer, Robinul Forte (glycopyrrolate) is indicated for other G-I conditions that may benefit from anticholinergic therapy. Robinul-PH Forte (glycopyrrolate 2 mg. with phenobarbital) is indicated when these situations are complicated by mild anxiety and tension.

Contraindications: Glaucoma, urinary bladder neck obstruction, pyloric obstruction, stenosis with significant gastric retention, prostatic hypertrophy, duodenal obstruction, cardiospasm (megaesophagus), and achalasia of the esophagus, and in the case of Robinul-PH Forte, sensitivity to phenobarbital.

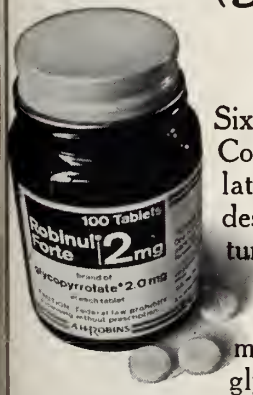
Precautions: Administer with caution in the presence of incipient glaucoma.

Adverse Reactions: Dryness of the mouth, blurred vision, urinary difficulties, and constipation are rarely troublesome and may generally be controlled by reduction of dosage. Other side effects associated with the use of anticholinergic drugs include tachycardia, palpitation, dilatation of the pupil, increased ocular tension, weakness, nausea, vomiting, headache, dizziness, drowsiness, and rash.

Dosage: Should be adjusted according to individual patient response. Average and maximum recommended dose is 1 tablet three times a day; in the a.m., early p.m., and at bedtime. See product literature for full prescribing information. Supply: Robinul (glycopyrrolate 1 mg.): Robinul Forte (glycopyrrolate 2 mg.): Robinul-PH (glycopyrrolate 1 mg.) with phenobarbital 16.2 mg. (Warning: may be habit forming): Robinul-PH Forte (glycopyrrolate 2 mg.) with phenobarbital 16.2 mg. (Warning: may be habit forming), in bottles of 100 and 500 tablets. A. H. Robins Company, Richmond, Va. 23220.

A·H·ROBINS

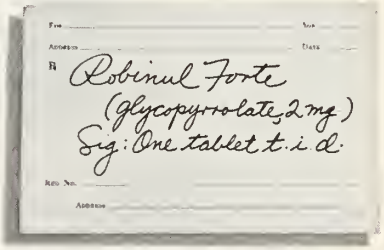
In peptic ulcer therapy, won't you give Robinul® Forte a Fair Trial?
(glycopyrrolate)



Six years ago the A. H. Robins Company introduced glycopyrrolate, a unique anticholinergic agent described in the prescribing literature as more closely approaching the ideal compound for controlling gastric hyperacidity and hypermotility of the G-I tract. Although glycopyrrolate (Robinul Forte) found good acceptance among numerous physicians, many others just didn't seem to want to give it a try, probably because the anticholinergic they were already using was giving acceptable results.

However, we believe you'll agree there's always room for a better anticholinergic. This is why we're asking you to give Robinul Forte a fair trial. Robinul Forte exerts a highly specific antisecretory action and marked inhibitory effect on intestinal tone. We're convinced you'll agree that this is indeed an outstanding drug when you observe its outstanding suppression of ulcer symptoms. Furthermore, it is unique in that it reduces intestinal tone, yet has little or no effect on peristalsis. In addition, the incidence of the more bothersome peripheral side effects is low.

No longer does the physician have to look for extreme dry mouth as the measure of his anticholinergic's effectiveness. The only way we can demonstrate to you firsthand the efficacy of glycopyrrolate (Robinul Forte) is for you to try it in your practice. That's why we're asking you to give it a Fair Trial. How can you give it a Fair Trial? You do it this way:



First: When you see your very next ulcer patient, write him a script as shown.

Next: Wait 10 days or until your patient comes in for his next appointment and get his "verdict" as to how he feels. Examine all the evidence and make your evaluation of his condition.



Finally: Render **your** verdict. If it's "significant improvement and marked relief of symptoms," then we believe you'll agree that Robinul Forte has proved its worth, and we rest our case. If not, consider our case for Robinul Forte closed. That's a Fair Trial, Doctor, and it's all we ask.

Robinul® Forte
(glycopyrrolate, 2 mg.)

The summation is an important part of every case. You'll find ours on the preceding page, Doctor.

Alabama Department of Public Health

Emergency Medical Services

By
H. Austin Hayes
Director, Division of Accident Prevention, Bureau of Primary Prevention, and
Ira L. Myers, M. D.*
State Health Officer

Accidents present a grave threat to the health and welfare of Alabamians. Each year approximately 2400 of our citizens die from accidental causes, making accidents our fourth leading cause of death. For ages one through 34, accidents are the number one killer. Even more staggering are the figures for those who are seriously injured—some permanently crippled and disfigured by their wound.

Anything which attacks our people to this extent demands a concerted effort by all of us to establish a sound program of prevention. An overall Accident Prevention Program consists of activities on three levels: (1) preventing the accident itself, where possible; (2) taking steps to prevent injury should an accident occur; and (3) providing adequate emergency medical services to reduce recovery time and prevent further complications when injury does occur. It is to this third activity, emergency medical services, that I address my remarks this afternoon.

The director of the field program of the American College of Surgeons has said that it is not unrealistic to believe that 20,000 of the 100,000 persons killed in accidents each year could be saved by adequate emergency medical services. If we apply this proportion to our experience in Alabama, we find that we should be able to save 500 lives per year through providing efficient emergency medical care. And there is much evidence to support the argument that we *could* save these lives.

Medicine has developed many life-saving methods and techniques in recent years. Advances in the care of trauma and acute shock and in cardiopulmonary resuscitation serve as excellent examples. Our experiences on the battlefield have shown that severely injured persons can be saved and extended periods of convalescence avoided by prompt application of these techniques at the site of the injury.

Comparison of our injury experience in urban centers with that of rural areas provides both an illustration of the effectiveness of these emergency procedures and an indication of the inadequacies of our total emergency medical services system. Studies have shown that in cases of similar injury, the victim of a rural highway accident is four times as likely to die as the victim of an urban accident—even though their injuries are identical! Why is this true? The same studies indicate that it is not unusual for the rural traffic accident victim to wait from one to two hours before medical care arrives. Many times the ambulance reaches the scene only to bring untrained attendants who believe that their only function is to transport the victim as quickly as possible to the nearest

(Continued on Page 152)

*Address by Ira L. Myers, M. D., to the Fifth Annual Governor's Traffic Safety Conference, June 20, Jefferson Davis Hotel, Montgomery.



NEW! THE RITTER COAGULATOR

from the makers of the famous Bovie electrosurgical units . . .

The Ritter Coagulator is a low-in-cost but high-in-quality electrocoagulation instrument for wall or shelf service in your office. Made by the makers of the famous hospital Bovie, it has been engineered to utilize every advantage of today's advanced state of electronic circuitry. It will coagulate, desiccate and fulgurate—and you can handle scores of day-to-day applications in dermatology, gynecology, rhinolaryngology and proctology. Easy, safe to operate. Compact—only 8½ x 5 x 4 inches. Ask for a demonstration.

DURR
Surgical Supply Co.

MONTGOMERY BIRMINGHAM HUNTSVILLE

(Continued from Page 150)

hospital. Under these circumstances one can readily understand the high death rate. Or consider the case reported in one of our leading magazines. This case involved a mortician who paid a bounty for DOA's brought to his mortuary rather than to the hospital. How would you like to be in the care of a person who knew this bounty existed when your life depended on his expert care?

These conditions demand that we take steps to improve and regulate the emergency medical care system in Alabama. Adequate care involves more than just transportation. First, it includes an efficient communications network which will permit prompt notification of authorities when an emergency exists. This network must then provide for ample interchange among the separate elements of the entire system. Communication between the ambulance and the hospitals, for example, can prove valuable by permitting the ambulance attendant or driver to inform the hospital as to the type of injuries sustained by his patients. This, in turn, enables the hospital to be better prepared to receive the patient when the ambulance arrives. This could be especially true in some of our small hospitals where the emergency room is not staffed by a physician around the clock. Early notification of the hospital as to injuries would make possible an earlier contact with the physician on call, thus shortening or eliminating the waiting period at the emergency room.

The truly effective communications system must also permit conversation between police and ambulance. These forces must frequently work very closely in emergencies—especially with regard to traffic accidents.

With communications established, then, the system responds with an ambulance, or ambulances, as the case may be. This is often one of the weakest links in the entire chain of care. An ambulance was first used in wartime as a mobile field hospital. The surgeon traveled back and forth behind the lines administering aid to the wounded. Somehow, the idea of the ambulance merely as a vehicle of transportation has crowded out this original purpose. We must return to the understanding that the most important function of the ambulance is to *take care to the patient.* Our ambulances must be equipped with necessary supplies and manned by adequately trained personnel to permit initial care at the scene of the accident. Certain medical emergencies must be treated within minutes if life is to be maintained and disability avoided. In many others, complications can be prevented by the utilization of basic rudimentary first aid measures. Ambulance personnel must be taught to recognize these different injuries and must be proficient in administering the needed care. Law enforcement officers must be educated to the need for on-the-site care so that they don't demand immediate removal of the victim when the ambulance arrives.

Ambulance drivers must be taught the need for care in transporting sick or injured persons to more advanced care. In most cases, if adequate care is given at the scene of the accident, there is no need for a screaming siren, flashing red light, run to the hospital. Indeed, in some cases, this is a most dangerous ride, and may, in the case of a fractured vertebra, actually be the cause of the patient's death as he rolls on the stretcher during a sharp curve. Each year, some emergency personnel are injured when the speeding ambulance is itself involved in an accident. This is especially tragic when the victim of the initial accident has already been picked up. The image of the ambulance must be returned to that of a mobile first aid unit, and speed from the scene to the hospital discouraged except in cases of extreme emergency.

Let us say then, that the ambulance has transported our victim to the nearest hospital. Here we find what has proven to be another weak link in our chain of care. It is not unusual for a person to arrive at the emergency room only to lie 30 minutes or an hour waiting for a physician to arrive. As earlier mentioned, better communications

may aid in improving this situation. Something must be done, however, to establish better staffing of our emergency departments. The absence of any pattern at all with the resultant haphazard staffing creates needless delays in the care of the accident victim or the acutely ill. Such delays may cause deaths which could have been prevented. Some method must be developed which will permit essential staff to be present on a very short notice even when personnel are not available to man the emergency department 24 hours a day. Both the ambulance and the hospital must be manned and equipped to handle the emergencies that arise. These, then, are the elements of a good emergency health services system: communications, initial care and aid, transportation, and prompt definitive care at the medical facility.

Where do we stand in Alabama with regard to such a system? Not, I'm afraid where we should. While we do not have complete information on our situation at this time, we do know that there are deficiencies in our set-up. (We will, by the way, have more complete information in the near future. I will discuss that shortly.)

Much of the ambulance service in Alabama has been provided in the past by funeral home operators. Therefore, in 1965, the Alabama Department of Public Health, in cooperation with the Alabama Funeral Directors Association, conducted a survey of funeral homes providing emergency transportation of the sick and injured. Fifty-eight funeral home directors responded to our questionnaire. Of these 58, 45 indicated that they did transport the sick and injured. Although limited in scope, the results indicated a need for improvement. For example, a majority of the ambulances, we found, were being manned by only one person. A minimum of two is required for effective service. Twenty of the respondents indicated that they did not have oxygen and oxygen breathing apparatus on their vehicles. Only about one-half of the personnel on the ambulances had received any training in first aid.

We recently completed the survey again—once more with the kind assistance of the Funeral Directors Association. The results were even more shocking than before. This time, 73 funeral directors responded to our questionnaire. Only 23 of the 73 homes responding indicated that they continued to provide emergency ambulance services. This was a 50 per cent decrease in availability of such services during the last three years! And once again, response indicated inadequate personnel and insufficient training. It must be pointed out that in February of this year, the minimum wage law was expanded to cover, in addition to other things, ambulance services.

These statistics are but a small sample of the problem in Alabama. In order to know where we really stand, the Alabama Department of Public Health is embarking this summer on a comprehensive survey of the entire emergency health services system in our state. It will document the conditions currently existing in other areas as well as that of the ambulance service.

The equipment we demand and the personnel, even at a minimum wage, are expensive. We can't really relate charges to the service rendered in an individual case since we neglect to consider that we must pay also for idle, standby time in order to achieve needed availability. There are several ways, however, to solve the financial problem. Public services must be paid for by the public sooner or later. If governmental subsidy is required to provide adequate and coordinated service, then we must face the issue squarely. Such support of an existing private company, usually under an exclusive franchise, is sometimes the least expensive method of providing quality care.

Some municipalities have found it more efficient to integrate ambulance services into an existing function—usually the police or fire department. This proves to be a rather costly arrangement, but has the advantage of using personnel who are already available 24 hours a day and usually facilitates the estab-

lishment of central dispatching.

The use of volunteers in some areas, particularly smaller communities, has worked out well. For such a system to be effective, however, a corps of truly dedicated individuals must be recruited to provide the service. They must have a station headquarters and have adequate personnel to man the vehicles 24 hours a day. Otherwise, the time lag with regard to response can be enormous.

Regardless of which type of service is provided, nonetheless, some system of regulation must be developed. Currently there is no regulation whatsoever of ambulance services in Alabama. Legislation is needed to give authority to license and certify ambulance operators and to set standards for the operation of emergency medical care systems. As already mentioned, the health department is currently directing efforts towards improvement of our system in Alabama. The survey which we will complete this summer will give us a basis to work on. We will then establish training programs to make it possible for interested persons to provide quality care. But without regulatory authority we can never achieve uniformly good service statewide.

The most vital element in the improvement of emergency medical service, then, is the interest and support of individual citizens and officials like you. We must overcome the widespread apathy and lack of concern. Frequently, one's first interest in such services comes when he or a member of his family faces a medical emergency. We must realize that the availability of emergency medical services is a public responsibility. We must come to the realization that human lives are far more important than material property. We have long demanded quality equipment and personnel to protect our property from fire. Let's demand no less for our lives and those of our loved ones. With your interest and support we will remove the barriers and help establish a service which we would always be glad to receive for ourselves if we needed it.

Q. How much does the **anticostive* hematinic** cost?

A. No more than costive hematinics cost!

The anticostive hematinic is
PERITINIC®
Hematinic with Vitamins and Fecal Softener

A tablet-a-day provides:

● Elemental Iron (as Ferrous Fumarate)	100 mg
● Dioctyl Sodium Sulfosuccinate (to counteract constipating effect of iron)	100 mg
Vitamin B_1	7.5 mg
Vitamin B_2	7.5 mg
Vitamin B_6	7.5 mg
Vitamin B_{12}	50 mcgm
Vitamin C	200 mg
Niacinamide	30 mg
Folic Acid	0.05 mg
Pantothenic Acid	15 mg

Bottles of 60

*

anticostive, *adj.* (*anti* opposed to + *costive* causing constipation.) Against constipation. Now isn't that a good idea in an iron-containing hematinic?

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A simplified approach to the practical management of hypertension



Enduron: (methyclothiazide) A basic building block for mild hypertensives



Excellent day-long Na^+ output, yet easy on the K^+

Enduron provides an excellent starting therapy. Your patient's sodium excretion is greatly enhanced. Yet potassium loss is low.

The therapeutic action is smooth, and persists for a full 24 hours. With Enduron you can prescribe convenient once-a-day dosage without skimping your patients on day-long thiazide effectiveness.

Of course, as with all thiazides, supplemental dietary potassium should also be considered.

Use Enduron as a basic therapy in patients with mild to moderate hypertension. A single 5-mg. tablet each day is ample in most cases.

Once a day, every day

ENDURON

METHYCLOTHIAZIDE

MILD TO MODERATE TO SEVERE



See Brief Summary on final page of advertisement

Enduronyl: Its deserpidine component adds response in moderate hypertension



Less frequent rauwolfia side effects than with reserpine

When you wish to build further response, consider shifting to Enduronyl.

Enduronyl adds a building block of *deserpidine*. This is a purified rauwolfia alkaloid available only from Abbott. It adds good antihypertensive and tranquilizing activity. Yet its incidence of untoward effects, particularly lethargy and depression, is lower than with reserpine.

Enduronyl is available plain or Forte. The latter provides its variation where most helpful, by doubling the deserpidine.

Use Enduronyl for patients throughout the broad range of mild to moderately severe hypertension.

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METHYCLOTHIAZIDE 5 mg. with DESERPIDINE 0.25 mg. or (FORTE) 0.5 mg.

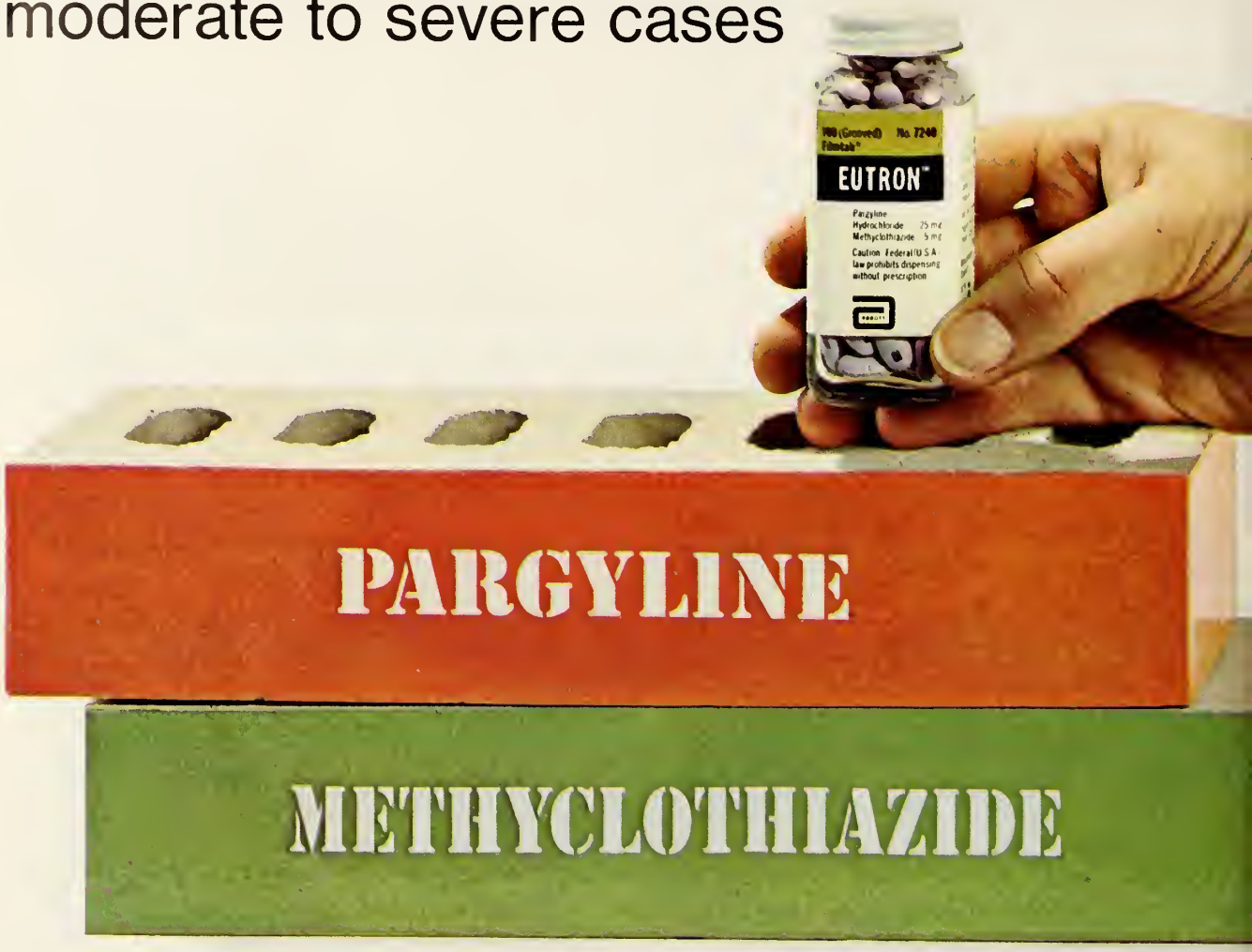
MILD TO MODERATE TO SEVERE



See Brief Summary on final page of advertisement

801094

Eutron: A unique combination for handling moderate to severe cases



Affords almost uniform diastolic reduction in all body positions

Eutron lowers diastolic pressures nearly equally, whether your patient is standing up or lying down.

Thus, in clinical trials, average *standing* diastolic readings were reduced from 112 pre-treatment to 90 post-treatment; *sitting* from 115 to 95; and *recumbent* from 112 to 94.

Note that following Eutron, the diastolic reductions were nearly alike in all three body positions.

Use Eutron for managing your moderate to severe cases. Its building blocks enhance each other; hence lesser doses often suffice.

Once a day, every day

EUTRON™

PARGYLINE HYDROCHLORIDE 25 mg.
with METHYCLOTHIAZIDE 5 mg.

MILD TO MODERATE TO SEVERE



See Brief Summary on final page of advertisement

ENDURON® | ENDURONYL®

METHYCLOTHIAZIDE

Each tablet contains Methyclothiazide 5 mg. with Deserpidine 0.25 mg. or 0.5 mg.

Indications: Edema and mild to moderate hypertension (Enduron), and mild to moderately severe hypertension (Enduronyl). More potent agents, if added, can be given at reduced dosage.

Contraindications: Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease or impending hepatic coma (hepatic coma due to hypokalemia has been reported in patients on thiazides). Do not use Enduronyl in severe mental depression, suicidal tendencies, active peptic ulcer, or ulcerative colitis.

Warnings: Consider possible sensitivity where there is history of allergy or asthma. If added potassium is indicated, dietary supplementation is recommended. Reserve enteric-coated potassium tablets for cautious use only when necessary, as they may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation often requiring surgery; discontinue them immediately if abdominal pain, distention, nausea, vomiting, or g.i. bleeding occurs. Neither Enduron nor Enduronyl contains added potassium.

Precautions: Use thiazides cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery, thiazides may reduce response to vasopressors, and increase response to tubocurarine. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia) in all patients. In hypokalemia (especially in digitalized patients) give supplemental potassium. In hypochloremic alkalosis, give supplemental chloride.

Use rauwolfias with caution in patients with history of peptic ulcer. Rauwolfias with anesthetics may produce hypotension and bradycardia. Discontinue Enduronyl two weeks before elective surgery. Consider vagal blocking agents during emergency surgery. In epilepsy, adjust anticonvulsant dosage. In electroshock, shorten stimulus strength and duration. In occasional patients with depressive tendencies, rauwolfias may precipitate severe mental depression that usually disappears when drug is stopped.

Adverse Reactions: Thiazide reaction include blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, serum uric acid or blood sugar; anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, symtomatic gout, and pancreatitis. Cutaneous vasculitis in the elderly has been reported with other thiazides. Adverse effects with deserpidine are qualitatively similar to those with reserpine, but their incidence is lower. These include nasal stuffiness, abdominal cramps or diarrhea, nausea, headache, weight gain, reduced libido and potency, peptic ulcer aggravation, epistaxis, skin eruption, asthma in susceptible patients, electrolyte imbalance, excessive salivation, and a reversible Parkinson's syndrome. Excessive drowsiness, fatigue, weakness, and nightmares may signal mental depression. Thrombocytopenia, purpura, and a symptom manifested by dull sensorium, deafness, uveitis, glaucoma, and optic atrophy are rare allergic reactions to other rauwolfias. Hypotension from antihypertensive agents may precipitate angina attacks in susceptible individuals. Usually adverse reactions disappear when drug is withdrawn.

EUTRON™

Each tablet contains Pargyline Hydrochloride 25 mg. with Methyclothiazide 5 mg.

Indications—Moderate to severe hypertension.

Contraindications—Pheochromocytoma, paranoid schizophrenia, hyperthyroidism and advanced renal failure. Not recommended in malignant hypertension, children under 12, pregnant patients.

Do not use with: centrally or peripherally acting sympathomimetic drugs; foods high in tyramine (e.g., aged and natural cheeses); parenteral reserpine or guanethidine; imipramine, amitriptyline, desipramine, nortriptyline or their analogues; other monoamine oxidase inhibitors; methyldopa or dopamine; separate Eutron and these agents by two weeks.

Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease; impending hepatic coma from thiazide-induced hypokalemia.

Warnings—Patients: 1. No other drugs (particularly "cold preparations" and antihistamines), cheese or alcohol without physician's consent. 2. Promptly report orthostatic symptoms, severe headache, other unusual symptoms. 3. Angina pectoris or coronary artery disease patients must not increase physical activity with improved anginal symptoms or well-being.

Physicians: 1. Use antihistamines, hypnotics, sedatives, tranquilizers and narcotics (meperidine contraindicated) cautiously in reduced doses. 2. Stop Eutron two or more weeks before elective surgery; in emergency surgery reduce premedication (narcotics, sedatives, analgesics, etc.) to 1/4 to 1/5; carefully adjust anesthetic dosage to patient response. 3. Use cautiously in advanced renal failure. 4. Pargyline may induce hypoglycemia. 5. Consider possible sensitivity reactions when a history of allergy or asthma is present. 6. If potassium is indicated, dietary supplement is recommended; enteric-coated potassium tablets may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation frequently requiring surgery; discontinue medication immediately if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs; Eutron does not contain added potassium. 7. Possible systemic lupus erythematosus has been reported for thiazides.

Precautions—Pargyline: Use cautiously at reduced dosage: caffeine, alcohol, antihistamines, barbiturates, chloral hydrate, other hypnotics, sedatives, tranquilizers, narcotics. Periodically do urinalyses, blood counts, liver function tests, etc. Use with caution in liver disease. Watch for orthostatic hypotension, especially in impaired circulation (e.g., angina pectoris, coronary artery disease, cerebral arteriosclerosis); also, augmented hypotension in concomitant febrile illnesses. Reduce or discontinue if hypotension is severe. In impaired renal function watch for cumulative drug effects, elevated BUN and other evidence of progressive renal failure; withdraw drug if these persist. In surgery increased central depressant response (hypotension and increased sedative effect) can be controlled by (1) discontinuing at least two weeks prior; (2) in emergency surgery lowering dose of premedication; (3) when necessary, administering a vasopressor. Do not use in hyperactive and hyperexcitable patients. Pargyline may unmask severe psychotic symptoms where emotional problems pre-exist. Use cautiously in Parkinsonism, especially with antiparkinsonian agents. In prolonged therapy, examine for change in color perception, visual fields, fundi and visual acuity. Also, prolonged therapy has made certain patients refractory to nerve blocking effects of local anesthetics.

Methyclothiazide: Use cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery thiazide may reduce vasopressor response and increase tubocurarine response. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia). Give supplemental chloride if hypochloremic alkalosis occurs and supplemental potassium if hypokalemia occurs (especially in digitalized patients). Thiazides may decrease serum P.B.I. without signs of thyroid disturbance.

Adverse Reactions—Pargyline: Orthostatic hypotension and associated symptoms, mild constipation, fluid retention, edema, dry mouth, sweating, increased appetite, arthralgia, nausea, vomiting, headache, insomnia, difficult in micturition, nightmares, impotence, delayed ejaculation, rash, purpura, weight gain, hyperexcitability, increased neuromuscular activity and other extrapyramidal symptoms. Drug fever is extremely rare. Reduction in blood sugar and hypoglycemic effects are possible. Congestive heart failure has been reported in a few patients with reduced cardiac reserve.

Methyclothiazide: Blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, blood sugar or serum uric acid (gout may be induced); anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice and pancreatitis. Cutaneous vasculitis in elderly patients has been reported with other thiazides.

If side effects are severe or persist, reduce dosage or withdraw drug. 804438R

ABBOTT

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Bureau of Vital Statistics

PROVISIONAL BIRTH AND DEATH STATISTICS AND COMPARATIVE DATA,

Ralph W. Roberts, M. S., Director

APRIL 1968

Live Births / Deaths / Causes of Death	Number Registered During April 1968			Rates* (Annual Basis)		
	Total	White	Non-White	1968	1967	1966
Live Births	4,997	3,418	1,579	16.9	16.2	17.8
Deaths	2,627	1,816	811	8.9	8.6	9.5
Fetal Deaths	118	55	63	23.1	18.8	22.0
Infant Deaths—						
under one month	88	54	34	17.6	19.1	17.4
under one year	123	76	47	24.6	26.9	29.6
Maternal Deaths	2		2	3.9	10.3	7.6
Causes of Death						
Tuberculosis, 001-019	13	7	6	4.4	6.5	6.6
Syphilis, 020-029	7	4	3	2.4	0.7	1.4
Dysentery, 045-048						0.7
Diphtheria, 055						
Whooping cough, 056	1		1	0.3		
Meningococcal infections, 057					1.0	0.3
Poliomyelitis, 080, 081						
Measles, 085					1.0	
Malignant neoplasms, 140-205	381	287	94	129.0	122.6	119.2
Diabetes mellitus, 260	51	36	15	17.3	14.3	20.7
Pellagra, 281	1	1		0.3		
Vascular lesions of central nervous system, 330-334	367	229	138	124.2	112.3	126.4
Rheumatic fever, 400-402	2	1	1	0.7		
Diseases of the heart, 410-443	905	661	244	306.3	289.2	337.2
Hypertension with heart disease, 440-443	86	32	54	29.1	34.4	46.3
Diseases of the arteries, 450-456	71	54	17	24.0	24.2	21.8
Influenza, 480-483	2	2		0.7	1.0	3.8
Pneumonia, all forms, 490-493	61	37	24	20.6	20.8	33.2
Bronchitis, 500-502	6	6		2.0	1.7	4.5
Appendicitis, 550-553					0.3	1.7
Intestinal obstruction and hernia, 560, 561, 570	8	3	5	2.7	3.4	3.1
Gastro-enteritis and colitis, under 2, 571.0, 764	4	2	2	1.4	1.4	1.4
Cirrhosis of liver, 581	14	11	3	4.7	6.1	4.5
Diseases of pregnancy and childbirth, 640-689	2		2	3.9	10.3	7.6
Congenital malformations, 750-759	22	20	2	4.4	5.7	6.4
Immaturity at birth, 774-776	24	11	13	4.8	4.6	4.6
Accidents, total, 800-962	200	146	54	67.7	68.3	58.7
Motor vehicle accidents, 810-835, 960	105	84	21	35.5	34.1	27.3
All other defined causes	352	230	122	119.2	117.8	133.4
Ill-defined and unknown causes, 780-793, 795	133	68	65	45.0	46.4	52.9

*Rates: Birth and death—per 1,000 population
Infant deaths—per 1,000 live births
Fetal deaths—per 1,000 deliveries
Maternal deaths—per 10,000 deliveries
Deaths from specified causes—per 100,000 population

BUREAU OF PREVENTABLE DISEASES

W. H. Y. Smith, M. D., Director

Current Morbidity Statistics

1968

	May	June	*E. E. June
Tuberculosis	94	126	120
Syphilis	67	70	137
Gonorrhea	558	384	310
Chancroid	2	0	3
Typhoid fever	0	0	2
Undulant fever	0	0	0
Amebic dysentery	3	1	3
Scarlet fever & strep. throat	364	350	61
Diphtheria	0	0	0
Whooping cough	1	3	9
Meningitis	5	4	6
Tularemia	0	0	0
Tetanus	0	2	1
Poliomyelitis	0	0	0
Encephalitis	0	0	0
Smallpox	0	0	0
Measles	12	13	234
Chickenpox	20	14	43
Mumps	49	50	47
Infectious hepatitis	22	18	34
Typhus fever	0	0	0
Malaria	1	3	0
Cancer	947	1,371	624
Pellagra	0	0	0
Rheumatic fever	18	16	17
Rheumatic heart	18	22	27
Influenza	36	17	30
Pneumonia	469	259	203
Rabies—Human cases	0	0	0
Pos. animal heads	4	1	0

As reported by physicians and including deaths not reported as cases.

*E. E.—The estimated expectancy represents the median incidence of the past nine years.

BUREAU OF LABORATORIES

Thomas S. Hosty, Ph. D., Director

June 1968

Examination of Intestinal Parasites	1,356
Examination of Malaria	11
Examination for Salmonella & Shigella (blood-feces-urine-food)	305
Examination for tubercle bacilli	4,761
Examinations for gonococci	2,160
Serological tests for Syphilis	31,679
FTA	75
Darkfield	3
Brucella	0
General Bacteriology (cultures for isolation and confirmation)	46
Staphylococcus (cultures for isolation and confirmation)	1
Examinations for diphtheria (cultures for isolation and confirmation)	2
Streptococci examinations	1,918
Mycology	37
Agglutinations	9
Vincent's infection	1
Complement fixation tests	219
Tests for Phenylketonuria (PKU)	5,653
Cytology	1,848
Water examinations	3,839
Milk and Dairy products examinations	5,366
Sea food examinations	134
Examinations for Negri bodies (smears & animal inoculations)	333
Virology	13
Rh Factor Bloods	754
Miscellaneous	1,522
Total	62,045



The Month in Washington

From the Washington Office
American Medical Association

Washington, D. C.—President Johnson designated the Secretary of Health, Education and Welfare, Wilbur J. Cohen, as the chief federal official for health policies and programs.

An HEW reorganization plan, recommended by Cohen and approved by Mr. Johnson, makes the secretary:

1) The President's chief adviser on federal health policy and programs.

2) Responsible for coordinating all federal health programs.

3) Head of a new Federal Interdepartmental Health Policy Council.

The reorganization also included creation of a Consumer Protection and Environmental Health Service as a unit of the Public Health Service and transfer of the Division of Regional Medical Programs from the National Institutes of Health to the Health Services and Mental Health Administration.

Mr. Johnson also agreed to renew a request to Congress to raise the status of HEW's principal health official, now Dr. Philip R. Lee, from assistant secretary to Under Secretary for Health and Science.

The new consumer and environmental health unit consists of:

—The Food and Drug Administration;

—The National Center for Air Pollution Control;

—The National Center for Radiological Health;

—The National Center for Urban and Industrial Health;

—Certain staff units of the Office of the Director, Bureau of Disease Prevention and Environmental Control.

Charles C. Johnson, Jr., a negro and Assistant Commissioner for Health for Environmental Health in New York City, was named to head the new unit. An engineer, he had been on leave from the Public Health Service and his new post makes him the highest ranking negro member in the history of PHS.

Dr. Herbert L. Ley, Jr., who had been director of the FDA's Bureau of Medicine since the fall of 1966, was appointed to succeed Dr. James L. Goddard who recently resigned as Commissioner of Food and Drugs. Dr. Ley, 44, had been recommended by Goddard and also had the support of a number of Senate and House members on committees concerned with FDA. A 1946 graduate of the Harvard Medical School, Dr. Ley had been on the faculty at his alma mater and the George Washington University School of Medicine earlier in his career. He also had served as chief of medical branches of the Army research office and the office of the Army Surgeon General.

The interdepartmental health policy council will oversee all federal activities in the health field, such as the drafting of physicians for service with the armed forces, Veterans Administration hospitals and Office of Economic Opportunity health projects.

Cohen said that there had been no way in the past for the HEW secretary to give guidance in such matters. He said there must be a reexamination of the drafting of physicians to provide care in the United States for civilian dependents of military personnel.

"This allocation of a portion of the critically scarce physician pool materially affects programs intended to make health care as

widely available as possible, a national health goal that goes far beyond the mission of the Department of Defense," Cohen said.

As medicare went into its third year, Cohen announced the appointment of a 12-member advisory council to study the possible extension of the program to disabled persons under age 65. Congress last year turned down the Administration's request for such an extension but authorized creation of the council to study the matter.

In discussing medicare, Cohen said rising health care costs had made financing of the program a serious problem. He said new financing, presumably a tax increase, may be required if costs continue to rise.

"Physicians must act with restraint on fees or people will ask government to put on controls," he said. "I would not like to see that."

Dr. Henry H. Kessler, director of the Kessler Institute for Rehabilitation in Newark, N. J., was named chairman of the advisory council. Other members are:

Dr. Morris Brand, medical director of the Sidney Hillman Health Center; James Brindle, president of the Health Insurance Plan of Greater New York; James M. Gillen, director of personnel research of General Motors; Juanita Kreps, associate professor of economics at Duke University; Dr. Leonard W. Larson, past president of the American Medical Assn.; Daniel W. Pattengill, vice president of Aetna Life and Casualty Co.; Bert Seidman, director of the AFL-CIO social security department; E. A. Vaughn, vice president of the Aluminum Co. of America; Anthony G. Weinlein, executive assistant to the president of the AFL-CIO Building Service Employes; E. B. Whitten, executive Director of the National Rehabilitation Assn., and Dr. Alonzo S. Yerby, professor at Harvard's School of Public Health.

* * *

The American Medical Association told Congress it supported most provisions of the Administration's health manpower bill as essential to increasing enrollment in the nation's medical schools.

The AMA position was outlined by Dr. William A. Sodeman of the AMA's Council on Medical Education in testimony before the House Public Health and Welfare Subcommittee. He noted that a recent joint statement of the AMA and the Association of American Medical Colleges that more funds from both government and private sources would be needed by medical schools if they were to expand enrollment.

"The bill (H. R. 15757) before the subcommittee provides a means of furnishing the Federal component of the necessary financial resources," Dr. Sodeman said.

In other testimony, the AMA supported the overall objectives of the Administration's occupational health bill. But the Association opposed a provision that would authorize establishment and enforcement of mandatory national standards for health and safety.

Dr. R. Lomax Wells, chairman of the AMA's Council on Occupational Health, told a Senate Labor Subcommittee, that the objectives of the bill (S. 2864) could "best be accomplished through the research, education and training provisions and through grants to states to enable them to undertake and conduct more effective programs in both occupational health and safety."

Urging rejection of the mandatory standards provision, Dr. Wells said that this authority has been "properly vested in the states where the standards and the enforcement can be adapted to their particular geographical and industrial conditions."

* * *

The U. S. Supreme Court refused, by a 5-4 division, to lay down a constitutional rule against punishing chronic alcoholics for being drunk in public.

In an opinion by Justice Thurgood Marshall, four members of the Court said that neither the facts of the test case nor "the comparatively primitive state" of scientific knowledge on the subject justifies such a decision at present.

The vote of the four, plus Justice Byron R.

White, who concurred separately, upheld the conviction of Leroy Powell, 67, who was fined $50 in a Travis County, Tex., court for being drunk in public.

The argument for Powell was that alcoholism is a disease and the person suffering from it should be treated rather than punished.

Two AMA authorities on alcoholism expressed surprise and disappointment at the court's decision. Dr. Marvin Block of Buffalo, N. Y., a member and former chairman of the AMA's Committee on Alcoholism and Drug Abuse, and Dr. Dana L. Farnsworth of Harvard University, chairman of the AMA Council on Mental Health took issue with the court opinion that "we are unable to conclude . . . that chronic alcoholics in general . . . suffer from such an irresistible compulsion to drink and get drunk in public that they are utterly unable to control their performance. . ."

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Dr. Truelove Director of Regional Technical Institute

James W. Truelove, Ed. D., has been appointed Assistant Professor to the faculty of the School of Health Services Administration, University of Alabama in Birmingham.

Matthew F. McNulty, Jr., Dean of the School of Health Services Administration, indicated that Dr. Truelove would serve as Director of the Regional Technical Institute for the Health Occupations. The Regional Technical Institute is a new department of the School of Health Services Administration.

A native of Tuscaloosa, Dr. Truelove has B. S., M. A. and Ed. D. degrees from the University of Alabama. His doctorate is in Educational Psychology and Administration. Having served as a Medical Service Corps Officer in the U. S. Air Force for a number of years, Dr. Truelove brings to the School of Health Services Administration a unique and valuable background in hospital administration and allied health educational administration.

He served a total of 12 years as Educational Advisor and Evaluation Officer at the Medical Service School, Gunter AFB, Alabama. And most recently he was Assistant Hospital Administrator and Executive Officer at the USAF Hospital in Tachikawa, Japan.

Under Dr. Truelove's directorship, the Regional Technical Institute will be developed for a September, 1969, opening. Funding in the amount of $952,000 for a building has been granted through the Appalachia Regional Development Act, and State bond issue funds were added for a total project amount of $1.19 million. The building is scheduled for completion in September, 1969.

Enrollment is estimated at 500 students a year when the Regional Technical Institute is in full operation. The allied health training will be on a post-high school, but sub-baccalaureate level.

Regional Technical Institute programs in the following areas are already in operation, having originated as Schools in the University of Alabama Hospitals and Clinics: Anesthesia for Nurses, Certified Laboratory Assistant, Cytotechnology Technician, Histologic Technician and Radiologic Technician. A Pathologist's Assistant program is also in operation.

Nine new programs are being developed for the Regional Technical Institute when the building is completed: Dental Assistant, Dental Laboratory Technician, Dietetic Supervisor, Dietetic Technician, Electroencephalography Technician, Inhalation Therapist, Occupational Therapy Assistant, Physical Therapy Assistant and Radioisotope Technician.

Joint Statement Issued On Venereal Diseases

"Today's VD Control Problem," a 62-page joint statement, has been written and published by The American Social Health Association. Assisting with this activity were the co-sponsors, The American Public Health Association and The American Venereal Disease Association, in cooperation with the American Medical Association and The Association of State and Territorial Health Officers.

Complimentary copies of this manual, which is an invaluable aid when formulating venereal disease control programs in any locality, have been mailed to state and county medical societies with the request that appropriate committees in their respective areas receive the information and launch worthwhile control programs at the community level.

Others interested in obtaining a copy of this publication may do so by sending $1.00 to the American Social Health Association, 1740 Broadway, New York, New York 10019. Special prices are available on quantity orders.

Fourth Quackery Congress to Be Held Oct. 2-3

The Fourth National Congress on Health Quackery will be held October 2-3 at Chicago.

Joint announcement of the Congress was made by F. J. L. Blasingame, M. D., executive vice-president of the American Medical Association, and Peter G. Meek, executive director of the National Health Council.

"Protecting the Consumer" will be the theme of the meeting.

"Health quacks bilk the American public of hundreds of millions of dollars every year," said Dr. Blasingame. "Their nostrums, health foods, and 'miracle cures' are not only frauds but frequently harm the patient by giving him the illusion that he is under medical treatment. The American Medical Association regards its continuing battle against quackery as one of its most important activities."

The Quackery Congress will be the opening event of "AMA Law Week," October 2-6. The Law Week program, also to be held at the Drake Hotel, is to include the Second National Congress on Medical Ethics and the biennial Legal Conference for Medical Society Representatives.

The National Health Council, co-sponsor of the Congress with the AMA, is the nation's largest organization of professional, governmental and voluntary agencies in the health field. They also co-sponsored the last previous Quackery Congress, held in 1966 in Chicago. Two earlier Congresses, in 1961 and 1963, were held in Washington, D. C.

About 500 to 600 persons representing medicine and allied health professions, government, and voluntary health organizations are expected to attend. Attendance will be by invitation.

Details, including the program of speakers, will be announced later. Inquiries should be addressed to: Joseph A. Sabatier, Jr., M. D., Chairman, Committee on Quackery, American Medical Association, 535 North Dearborn Street, Chicago, Ill. 60610.



Determination of Need for Medical Evaluation in Driver Licensing

A new attack has been launched on the problem of providing a more adequate method of determining the fitness of applicants for driver's licenses. The spearhead of the attack is a new guide, "Determination of Need for Medical Evaluation in Driver Licensing," just developed by the AMA Committee on Medical Aspects of Automotive Safety.

This guide, aimed at non-medical licensing authorities, suggests a screening procedure to be used on all license applicants, with only those seeming to present an unwarranted risk as drivers being required to have an examination by a physician. To do such screening effectively, lay licensing authorities will have to have medical advice and guidance. The Committee on Medical Aspects of Automotive Safety suggests that state medical association committees on automotive safety work very closely with state licensing authorities and also with county medical societies.

In addition to improving licensing procedures, the AMA Committee feels that this new guide will go a long way toward eliminating agitation for legislation which would require medical examinations for **all** drivers, as well as that which proposes compulsory reporting by physicians of conditions in their patients which might make driving unsafe. Both of these principles have been opposed by the medical profession for many reasons, principally that they are unworkable. In addition, the compulsory reporting proposal is felt to interfere with the confidentiality of medical records as well as with the traditional physician-patient relationship.

"Determination of Need for Medical Evaluation in Driver Licensing" was published originally in the March 4th issue of The Journal of the American Medical Association, and reprints were distributed April 5 to state medical associations. Individual copies may be obtained from the Committee on Medical Aspects of Automotive Safety, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

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Recommendation of The Public Health Service Advisory Committee on Immunization Practices

Published in Morbidity and Mortality Weekly Report

Vol. 16, No. 32, week ending August 12, 1967

The Public Health Service Advisory Committee on Immunization Practices meeting on May 26, 1967, issued the following recommendation on measles vaccines, the second revision of the initial recommendation which appeared in the MMWR, Vol. 14, No. 7 (February 20, 1965). (The first revision appeared in the MMWR, Vol. 14, No. 36, September 11, 1965.)

MEASLES VACCINES

Introduction

Highly effective, safe vaccines are available for eliminating measles in the United States. Collaborative efforts of professional and voluntary medical and public health organizations are directed toward eradicating the disease in 1967. Unless protected by vaccine, virtually all children will at some time have clinically evident measles. Measles is often a severe disease; it is of particular concern because of frequent complications, including bronchopneumonia, middle ear infection, and encephalitis. Encephalitis, which follows measles in approximately one of every 1,000 cases, often causes permanent brain damage and subsequent mental retardation. An average of one measles death occurs for every 10,000 cases.

All susceptible children—those who have not had natural measles or measles vaccine—should be immunized. It is particularly important to immunize children that are still susceptible on entering nursery school, kindergarten and elementary school, because they are often responsible for transmission of measles to other children in the community. Communities should establish programs directed toward vaccinating all children at about one year of age.

Live Attenuated Measles Virus Vaccine (Edmonston and Schwarz Strains)

Live attenuated measles virus vaccine* prepared from the Edmonston or Schwarz (further attenuated) measles virus strains is widely used in the United States. The Edmonston strain is propagated in either chick embryo or canine renal cell culture; it may be given alone or with Measles Immune Globulin according to the manufacturers' directions. The Schwarz strain is prepared only in chick embryo cell culture; it is suitable for administration without Measles Immune Globulin.

The live attenuated measles virus vaccines produce a mild or inapparent, non-communicable infection. Fifteen per cent of those receiving either the Edmonston strain with Measles Immune Globulin or the Schwarz strain experience fever, with temperatures of 103°F (rectal) or higher, beginning about the sixth day after vaccination and lasting no longer than 5 days. About twice as many (30 per cent) of those receiving Edmonston strain without Measles Immune Globulin have similar responses. The great majority of reports indicate that even children with high fevers

*The official name of the product in use is: Measles Virus Vaccine, Live, Attenuated.

experience relatively little discomfort and minimal toxicity. As a result, febrile reactions often go unnoticed by the parents.

An antibody response develops in virtually all susceptible children who are given live attenuated measles virus vaccines. Edmonston strain vaccine administered without Measles Immune Globulin induces a level and persistence of antibody corresponding to that seen following regular measles. Antibody titers in response to Edmonston strain with Measles Immune Globulin or to Schwarz strain are slightly lower. However, all three of these vaccine schedules appear to confer lasting protection against naturally occurring measles.

Experience with more than 20 million doses administered in the United States by early 1967 indicates that live attenuated measles virus vaccines are among the safest immunizing agents available. To date, serious reactions associated with their use have been very rare.

Recommendations for Vaccine Use

Age

For maximum efficacy, live attenuated measles virus vaccine should be administered when children are at least 12 months old. It can be given to infants at 9 to 12 months of age realizing that the proportion of vaccine responses may be slightly reduced. The proportion is further decreased if Measles Immune Globulin is administered with the vaccine. Vaccination of adults at the present time is rarely necessary, because nearly all individuals are immune by age 15. Limited data indicate that reactions to vaccine are no more common in adults than in children.

High Risk Groups

Immunization against measles is particularly important for children with chronic illnesses, such as heart disease, cystic fibrosis, and chronic pulmonary diseases, as well as for children with malnutrition and those living in institutions.

Prevention of Natural Measles Following Exposure

Live attenuated measles virus vaccine can usually prevent disease if administered *before or on the day of exposure* to natural measles. Limited studies reported to date indicate that protection is not conferred when vaccine is administered after the day of exposure, nor are adverse effects induced by measles immunization following exposure.

Precautions in the Use of Live Attenuated Measles Virus Vaccines

Severe Febrile Illnesses

Vaccination should be postponed until recovery is complete.

Tuberculosis

The exacerbations of tuberculosis that have been related to natural measles infection, by analogy might accompany infection with live attenuated measles virus. Therefore, any individual with known active tuberculosis should be under treatment when given measles vaccine. Although tuberculin skin testing is desirable as part of ideal health care, it need not be a routine prerequisite in community measles immunization programs. The protection against natural measles outweighs the theoretical hazard of possible exacerbation of tuberculosis infection by the administration of vaccine.

Recent Immune Globulin Administration

After administration of immune globulin, immunization should be deferred for 3 months. Persistence of measles antibody from the globulin may interfere with response to the vaccine.

Marked Hypersensitivity to Vaccine Components

Measles vaccine produced in chick embryo cell culture should not be given to children

hypersensitive to ingested egg proteins. Similarly, vaccine produced in canine cell culture should not be administered to children highly sensitive to dog hair or dog dander. To date, no reactions of the anaphylactic type following measles vaccine have been reported in the United States.

Contraindications to Use of Live Attenuated Measles Virus Vaccine

Leukemia, Lymphomas, and Other Generalized Malignancies

Administration of live attenuated measles virus vaccine to children with leukemia has occasionally been followed by severe complications such as fatal giant cell pneumonia.

Theoretically, attenuated measles virus infection might be potentiated by other severe underlying diseases, such as lymphomas and generalized malignancies.

Altered Resistance from Therapy

Steroids, alkylating drugs, antimetabolites, and radiation may predispose to untoward complications due to altered resistance.

Pregnancy

Purely on speculative grounds, physicians are reluctant to risk causing fetal damage that might theoretically be related to attenuated measles virus infection.

Management of Patients with Contraindications to Live Attenuated Measles Virus Vaccines

If immediate protection against measles is required for persons in whom use of live attenuated measles virus vaccine is contraindicated, passive immunization with Measles Immune Globulin (dose 0.25 ml/kg) should be given as soon as possible after a known exposure. It is important to note, however, that the preventive dosage of Measles Immune Globulin effective in normal children may not be equally so in children with acute leukemia. Inactivated measles virus vaccines* may induce longer lasting protection than provided by Measles Immune Globulin, but many children with leukemia and those receiving immunosuppressive drugs respond poorly.

Prior Immunization with Inactivated Measles Vaccine

Atypical measles, sometimes severe, following exposure to natural measles, has occasionally been observed in children previously immunized with inactivated measles virus vaccines. Untoward local reactions such as induration and edema have at times been observed when the live measles virus vaccine was administered to persons who had received inactivated vaccine previously.

Despite these reported instances of unusual associations, children who have been given inactivated measles vaccine should also be given the live vaccine for full and lasting protection against natural infection.

Simultaneous Administration of Live Virus Vaccines

Data on simultaneous administration of live virus vaccines are not sufficient to develop comprehensive recommendations; but there are obvious practical advantages to combining vaccines, and investigations are underway which should help to define optimal practices. When combined administration is indicated, available data do not suggest that undesirable responses will result. The following comment presents current atti-

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*Inactivated vaccines derived from Edmonston strain measles virus and prepared either in chick embryo or monkey cell cultures are available (Measles Virus Vaccine, Inactivated). These vaccines should be administered in a three-dose schedule at monthly intervals with a subsequent booster 6 months later. Following primary immunization with inactivated measles virus vaccine, the protection achieved in normal children has been satisfactory for the first few months, but has been shown to decline rapidly thereafter. Inactivated measles virus vaccines should not be used for immunizing normal children.

tudes toward scheduling vaccination with three major live virus vaccines—polio, measles, and smallpox.

It has been generally recommended that immunizations with live virus vaccines be separated by at least one month whenever possible. The rationale for this recommendation is the theory that superimposed reactions and diminished antibody responses might result if two or more live virus vaccines were given simultaneously. Ideally, the initial doses of oral poliovirus vaccine should have been given before a child reaches one year, the age for giving live attenuated measles virus vaccine. Administration of polio and measles antigens should be separated by at least one month. It is likewise desirable to separate measles and smallpox vaccinations by one or more months because both of these antigens may produce febrile reactions.

When, however, immunization program effectiveness is hindered or when the threat of concurrent exposures exists, the relevant live virus vaccines should be given at the same time. Observations do not indicate that this will cause a significant increase in adverse reactions or depressed antibody responses to either antigen.

Community Immunization Programs

Ongoing Programs

Universal immunization as part of good health care should be accomplished through routine and intensive programs carried out in physicians' offices and public health clinics. Programs aimed at immunizing children against measles at about one year of age should be established by all communities. In addition, all susceptible children entering nursery school, kindergarten, and elementary school should receive vaccine because of their particular role in community spread of natural measles.

Community-wide Mass Programs

Mass immunization programs can be useful supplements to the continuing use of live attenuated measles virus vaccine. Many have been organized as part of community measles eradication campaigns. The following points should be considered in planning mass immunization programs:

1. The active cooperation of private physicians and official health agencies normally concerned with the care of children is important.

2. Because live attenuated measles virus vaccines are administered parenterally, adequate numbers of medical and nursing personnel are required.

3. Despite increased public awareness of measles and its frequent, serious complications, substantial effort may be required to attain complete community support.

4. Although a number of children may have febrile reactions to live attenuated measles virus vaccine, extensive experience in community-wide campaigns and in private medical practice indicates that only a small fraction of these reactions requires medical attention. Parents should be told what reactions to expect, to avoid undue concern after the program gets underway.

Control of Measles Epidemics

Studies have shown that measles epidemics can be curtailed or halted in a community by prompt administration of live attenuated measles virus vaccine to *selected* groups of children, particularly the susceptibles in nursery school, kindergarten, and the first two or three grades of elementary school. However, once measles is widely disseminated in a community, it may be necessary to immunize susceptible children of *all ages* to alter the course of the epidemic.

Continued Surveillance

Careful surveillance of measles and its complications is necessary for appraising the effectiveness of national measles immunization programs, particularly measles eradica-

tion efforts. Such activities can delineate failures to achieve adequate levels of protection and define groups for which epidemic control programs should be instituted.

Although more than 20 million doses of measles virus vaccine had been administered in the United States by early 1967, continuous and careful review of adverse reactions is still important. All serious reactions should be carefully evaluated and reported in detail to local and State health officials so that collaborative national surveillance can be effective.

Immunization Schedules

Recommended immunization schedules are shown in the table at right:

IMMUNIZATION SCHEDULES FOR MEASLES VACCINES

Type of Vaccine	Age	Doses & Administration*
Live attenuated measles virus vaccine (Edmonston Strain)	12** months and older	1
Live attenuated measles virus vaccine (Edmonston Strain) plus Measles Immune Globulin	12** months and older	1 Plus Measles Immune Globulin (0.01 ml per lb. at different site with different syringe)
Live "further attenuated" measles virus vaccine (Schwarz Strain)	12** months and older	1

*Manufacturers' directions regarding administration should be followed.

**May be given to infants between 9 months and 1 year with the expectation of slightly decreased efficacy especially if administered simultaneously with Measles Immune Globulin.





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Warning: Tandearil is an analog of phenylbutazone; sensitive patients may be cross-reactive. If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Persistent or severe dyspepsia may indicate peptic ulcer; perform upper gastrointestinal x-ray diagnostic tests if drug is continued. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with caution in the first trimester of pregnancy and in patients with thyroid disease.
Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia), sudden weight gain (water retention), skin reactions, black or tarry stools or other evidence of intestinal hemorrhage occur. Make complete blood counts at weekly intervals during early therapy and at 2-week intervals thereafter. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.
Adverse Reactions: The more common are nausea and edema. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension, the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reacti-

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te a latent peptic ulcer. The patient should instructed to take doses immediately after eals or with milk to minimize gastric upset. ug rash occasionally occurs. If it does, omptly discontinue the drug. Agranulocysis, exfoliative dermatitis, Stevens-Johnson ndrome, Lyell's syndrome (toxic necrotizg epidermolysis) or a generalized allergic action similar to a serum sickness syome may occur and require permanent thdrawal of medication. Agranulocytosis n occur suddenly in spite of regular, reated normal white counts. Stomatitis, saliry gland enlargement, vomiting, vertigo and nguor may occur. Leukemia and leukemoid actions have been reported. While not definely attributable to the drug, a causal relanship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity, angiitis, pericarditis and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

Dosage in Osteoarthritis: Initial: 3 to 6 tablets daily in divided doses. Usually unnecessary to exceed 4 tablets daily. A trial period of one week is considered adequate to determine the therapeutic effect of the drug. Maintenance: Effective level often achieved with 1 or 2 tablets daily, should not exceed 4 tablets daily. In selecting appropriate dosage in any specific case, consideration should be given to the patient's weight, general health, age and other factors influencing drug response. Availability: Tan, round, sugar-coated tablets of 100 mg. in bottles of 100 and 1000.

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Allergies Are Not To Be Sneezed At

Every year a wave of misery sweeps the land—borne by an invisible sneeze-provoking cloud that stings the eyes and stuffs the nose.

Usually from mid-August until autumn chills the air, millions of Americans are caught up in a wheezing, coughing, nose-blowing, eye-wiping fit known as hay fever and caused by plant pollens, particularly those sown in the breeze by ragweed.

While virtually unknown in Europe and most other parts of the world, hay fever appears to be a growing medical problem in this country. One allergy expert speculated that the increases in respiratory allergies may be due to economic factors. Land once under cultivation is now being allowed to revert to weeds, the dusty-topped members of the Ambrosia (ragweed) family among them. Others believe the upsurge may stem from the fact that so many Americans lead such cocooned lives they never build up any natural immunity through gradual contact with pollens.

Plant pollen undoubtedly is the most publicized cause of allergic reactions. Many newspapers and radio stations keep daily track of the pollen count during the summer. But it is by no means the only source, and perhaps not even the most common when you consider that ordinary household dust may produce hay fever-type symptoms just as readily as pollens. Nor are allergies confined to the respiratory system. They have been triggered in various parts of the body by a myriad of things ranging from food, clothing, plastics and metals to insect hairs, cooking odors, heat or cold and modern wonder drugs.

Dr. Richard A. Kern of Philadelphia, a specialist in the field, says about 40 to 45 per cent of Americans are believed sensitive in at least some degree to one or more allergens (allergy producing agents).

Why is it that some people are "allergic" and others not? There is no definite answer yet. It has been found, however, that allergies appear to be tightly connected with our internal, involuntary defense system—the mechanisms and materials the body rallies to protect itself.

Sneezing, for instance, is an attempt by the body to forcefully expel an irritant, such as a pollen grain which has settled in the nasal passages. If the bit of pollen is blown out, all well and good. If not then another defense maneuver starts. The tissues swell to emit heavy discharges of mucus in an effort to wash out the irritant. Should this prove futile, the sneezing and mucus discharge continues and you begin to have the classic symptoms of hay fever.

Just why a substance such as pollen should severely irritate one nose and not another isn't really clear yet. But it may be that in some people the pollen and mucous membrane form a strong chemical bond, while in others the body chemistry is slightly different and no bond takes place.

On the other hand, it may be that the pollen merely sets in motion other chemical reactions which the body resists. It is known, for example, that when an allergy-producing substance is present body cells emit an abnormal amount of histamine. This chemical, found in all tissues, is probably a part of the body's defenses. It causes the small blood vessels to expand, which in turn enables them to carry more blood to the affected part.

Some specialists think that an allergic person may react to his own histamine. Drugs which suppress the production of this chemical have been used effectively to control body reactions to allergens.

By far the most perplexing allergy experience by physicians today is that produced in some people by life-saving drugs such as anti-

A Science Feature Article prepared by the Communications Division, American Medical Association.

biotics, vaccine serums and the hormone ACTH.

These drugs are injected into the body to fight disease. But the body doesn't realize this. To the body such drugs are a foreign substance and therefore must be expelled or neutralized.

To do this, the blood and/or lymph cells produce special chemicals known as antibodies. These are precisely tailored to neutralize one particular type of invader. Normally the whole reaction is routine. The right antibody is produced, the drug eventually is neutralized (although not before it has accomplished its intended work), and all returns to normal.

In a few individuals, however, the introduction of a certain drug produces within the body a state of high sensitivity. When this occurs, subsequent shots of the same drug can produce shock, unconsciousness, coma or death.

It has been speculated that in such cases the body produces too many antibodies, manufactures the wrong kind or delivers them to the wrong place in the body. It is also possible that the body in effect becomes allergic to its own antibodies.

Food is another frequent cause of allergic reactions. These can range from mild indigestion, skin rashes or hives to death. Dr. Jerome Glaser of the University of Rochester notes there is growing evidence that perhaps a few unexplained infant deaths may be caused by an allergic reaction to cow's milk.

Normally food proteins, which seem to be the cause of digestive allergies, are broken down in the process of digestion. But if a person's body isn't capable of breaking down a certain protein in a certain food then a reaction may result.

The skin is another area, frequently susceptible to allergies. Such allergies, Dr. Kern said, appear to develop more readily when the skin is wet. Thus a baker's hands may become allergic to the flour in the dough he kneads, or a housewife's hands to the detergent in her dishpan.

Evidence is strong that allergies are a combination of heredity and environment. "Heredity," said Dr. Kern, "accounts for the inborn quality of easy sensitization. Environment overwhelmingly determines the things to which a person becomes sensitive."

A sensitive person, he notes, is often susceptible to more than one allergen, as if the condition is a general weakness. Thus a city dweller, known to be allergic to cucumbers, may find that down on the farm he is allergic to chicken feathers as well.

It has been estimated that there are nearly 17,000,000 cases of allergy in the United States. Of these, hay fever afflicts about one person out of 20.

There are a number of other common respiratory allergies quite similar to hay fever, except they are caused by an allergen other than pollen. This often makes for a more troublesome ailment since there is no "off season" as there is for hay fever.

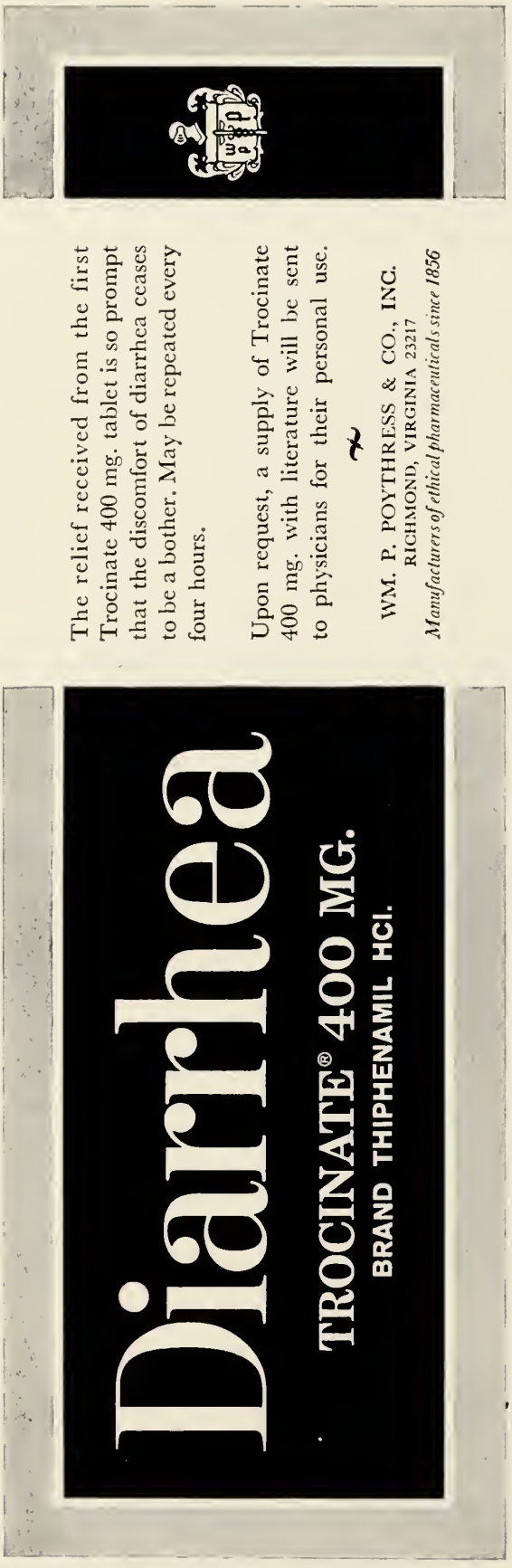
In general hay fever and similar conditions are merely miserable. But there is a hidden danger—asthma.

Asthma is the most serious of the common allergic diseases, responsible for perhaps 10,000 deaths annually, according to one estimate.

In asthmatic cases, the irritation, which may start in the nasal passages, proceeds into the bronchi—the air passages leading to the lungs. This causes the bronchi to constrict so that the victim has difficulty breathing. The lack of breathing capacity in turn may overtax the heart.

Medicine didn't really begin to come to grips with allergies until about the turn of the century, principally because they were so little understood and so difficult to recognize. Even today it may take months of testing to determine what touches off an allergic

(Continued on Page 176)



(Continued from Page 175)

reaction. Sometimes the cause is never found.

The test method usually employed is to implant a bit of the suspected allergen in the skin. If a reaction takes place—swelling and inflammation—then it is pretty certain that the patient is allergic to that substance.

Such tests while not foolproof, often enable a physician to determine in advance whether his patient is allergic.

When the cause of an allergy is discovered, it frequently becomes possible to clear up the condition by administering minute doses of the allergen so that the body gradually can build up immunity.

When treatment isn't possible, however, the only avenue of escape is to stay clear of the allergen. This can be rather difficult. People allergic to grass sometimes have to remain indoors in an air-conditioned climate. And a person allergic to such foods as wheat flour, eggs, milk, or even cooking odors, can find life quite a trial.

"For some reason," complained one sufferer, "people seem to think the victim of an allergy makes the butt of a good joke. But when you're even allergic to the tissue you use to blow your nose, believe me it's not very funny."

• Americans covered by private health insurance as of December 31, 1967 include an estimated 150 million for surgical expense and 121 million for medical expense insurance.

• In 1966, some 1,785 insuring organizations in the U. S. provided health insurance protection to the public.

• This total included 1,045 insurance companies, 75 Blue Cross and 75 Blue Shield plans, and nearly 600 "independent" health insurance plans.

—Reprinted from Health Insurance News

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Contraindications: Known hypersensitivity to drug; children under 6 months of age; acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in treatment of psychotic patients, and should not be employed in lieu of appropriate treatment. As with most CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increase in dosage of standard anticonvulsant medication; abrupt withdrawal in such cases may also be associated with temporary increase in frequency and/or severity of seizures. Advise patients against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance. Keep addiction-prone individuals (such as drug addicts or alcoholics) under careful surveillance because of their predisposition to habituation and dependence. Use of any drug in pregnancy, lactation or in women of childbearing age requires that potential benefit be weighed against possible hazard.

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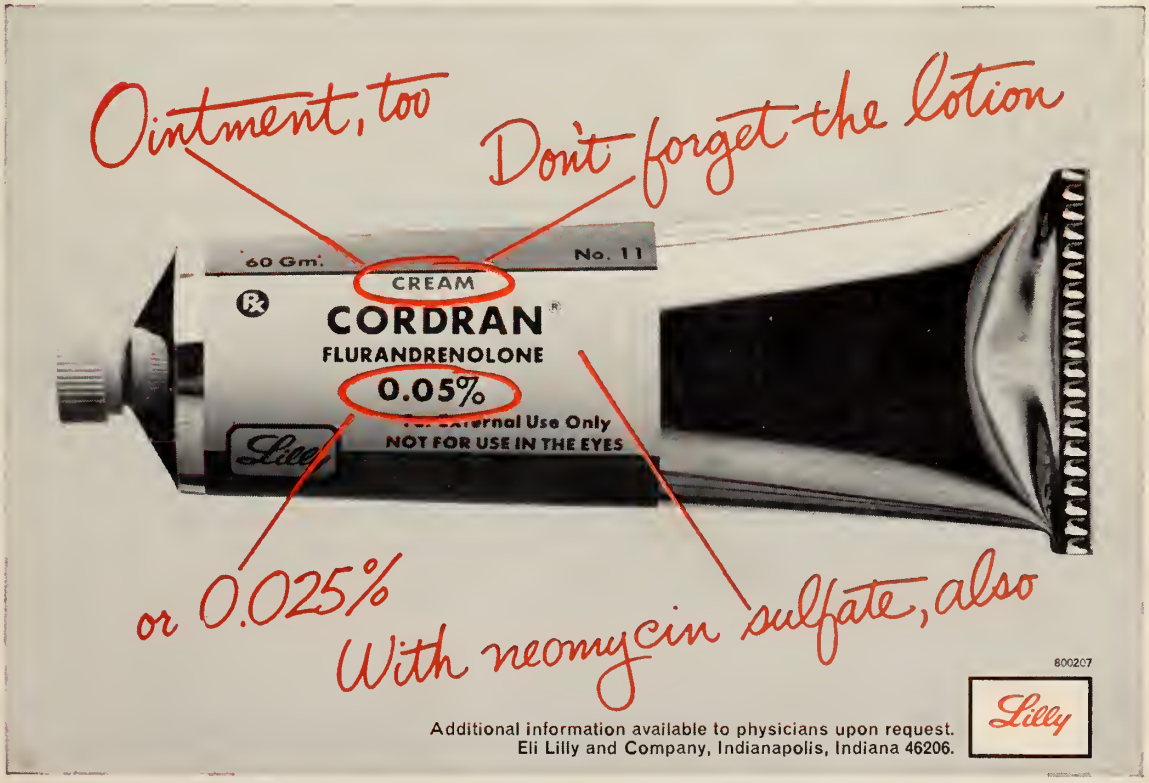
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SEPTEMBER 1968



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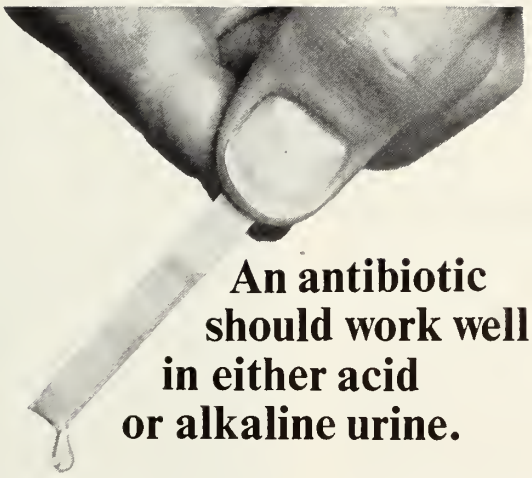
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Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

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President's Page



E. L. McCafferty, Jr.

In the past several months we are hearing the question raised more often "Can we govern?" And to me this indicates that more and more people question our ability to live and prosper under a free and democratic society. This question in itself is shocking for I believe as do the great majority of the American people that with all of its imperfections democracy is the best form of government and that before the pendulum of inertia swings too far a philosophy of government will again evolve that has over the years made America great. That democracy needs the support of all of society and not simply a vocal minority is unquestionable. In this election year I urge each of you to participate in the various campaigns at all levels actively as well as financially.

Democracy needs you now—and each candidate needs to be made aware of the needs of organized medicine in order for it to provide the best medical care that we possibly can. This is our responsibility and unless we formulate and provide for an atmosphere in which we can do our job to the best of our ability no one else will do it for us.

Dr. Wilbur, President of the AMA in his inaugural address states "Medicine's participation in health care planning must include developing legislative programs at the national, state and local levels."

If we are to participate in developing legislative programs then we must also participate in electing officials who will give us a fair hearing and make an honest effort to promote those programs that will prove beneficial to the welfare of the people. As citizens we are interested in electing officials who will govern wisely; and to be heard after an election it is necessary that we be heard prior to the election by candidate support and active involvement in a candidate's campaign.

ALAPAC has done a tremendous job in candidate support and has helped place the Medical Association in a most favorable light and yet organized medicine is only one facet in the overall business of government that needs the considered judgments of each voter. I would like to call your attention to your responsibility as citizens, as leaders in your community, and urge you to participate in the campaign of your selected candidate and most important vote on election day.

It is always gratifying to win; however even though your candidate may lose it is probable that the campaign has made some effect on the community and most important, you can feel rewarded for having done your duty in a democratic society. None of us can imagine losing the right to select government

officials through open and free elections, to be governed by dictatorship, but if we fail to vote then we temporarily voluntarily surrender our rights toward a democratic type of government and we are in effect living under a transient dictatorship.

To vote in a presidential election year is important and following the nominations for the presidency we will be exposed to many political speeches, but I would also remind you that other officials will be elected and each of them in his own way will also influence the government under which we will live for the next four years. Therefore it is well to become knowledgeable regarding not only the presidential election but those other officers on a national, state and local level.

Frequently we cover up our lack of political interest by saying that we are not in favor of either candidate and therefore will not vote; however I would suspect that by diligent effort and investigation of a candidate's record a physician would find that the philosophy of one of the candidates more closely resembles his own than the others. Since none of us thinks exactly alike in all matters it is necessary to judge the entire record of the candidate rather than one isolated instance in which we may not have the full background that influenced his vote in that specific roll call. To fail to make some selection is no answer since eventually one candidate will be elected and that candidate will govern each of us during the term of office to which he is elected. Thus it is hoped, under a democratic system that by a vote of all the people the final majority will select the individual best qualified and most likely to promote legislative views that represent the people governed.

It is interesting to note that in the national elections following the student riots in France this summer that 80 per cent of the qualified voters participated in the election—and to compare this percentage with the published figures in the Democratic primary held in Alabama in 1968—out of 1,389,198 qualified voters only 40 per cent participated in the selection of a candidate who will in most instances represent them over the next years.

In the national elections if 65 per cent of the qualified voters participate it is considered representative; this obviously isn't good enough and it behooves each of us to express our opinion in the coming elections—and to participate vigorously in the final selection of the candidates for in the final analysis as has often been quoted it is "Better to light one candle than to curse the darkness."

E. L. McCafferty Jr.

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AUXILIARY PLEDGE

"I pledge my loyalty and devotion to the Woman's Auxiliary to the American Medical Association. I will support its activities, protect its reputation and ever sustain its high ideals."

My husband and I have recently returned from a trip to Mexico, where we toured Mexico City, Taxco and Acapulco. We found this to be a country of contrasts, the ancient and the modern, churches, beaches, colorful dances and music, mountains, Old World atmosphere, interesting shops containing silver, brass and copper.

Upon asking questions of our guides, we learned that there is no Welfare program there, although there is a great deal of poverty and need; there is a Social Security program, and a portion of the money collected in the weekly National Lottery is given to the poor. The winning numbers in the Lottery are posted in conspicuous places throughout the cities, and the people look anxiously at them as they pass hoping they have been the lucky ones.

We saw many new housing projects being erected, to replace the shacks in which many of the poverty groups now live. We saw many delightful children, who learn very young how to beg from the "rich Americans," and who will pose for a picture if given a "peso." We enjoyed our visit in this beautiful country, but it was good to be at home again, in the best country in the world.

The Auxiliary work continues through the summer months, although at a slower pace than in the Fall and Winter months. On July 29, there was an Executive Board meeting, at which time we discussed our plans for the months ahead presented by the officers and chairmen. On August 19, I attended a Luncheon and Fashion Show in Birmingham, as the guest of the Jefferson-Birmingham Auxiliary. The second Annual Rural Health Conference was held in Montgomery on August 21. My calendar is full for September, when I shall begin my travels over the state to visit the Auxiliaries, and I shall see the "Auxiliary in Action," speaking to and with the members, discussing plans and problems, and just plain "girl talk."



Mrs. Robert K. Wilson, Sr.

From things I have been reading, it seems that more drastic changes in medical care are foreseen in the future. Many adjustments have had to be made already, and there are more ahead. We must be prepared for these, and be ready to meet the demands and challenges of a changing society and world. The times in which we live truly demand our best.

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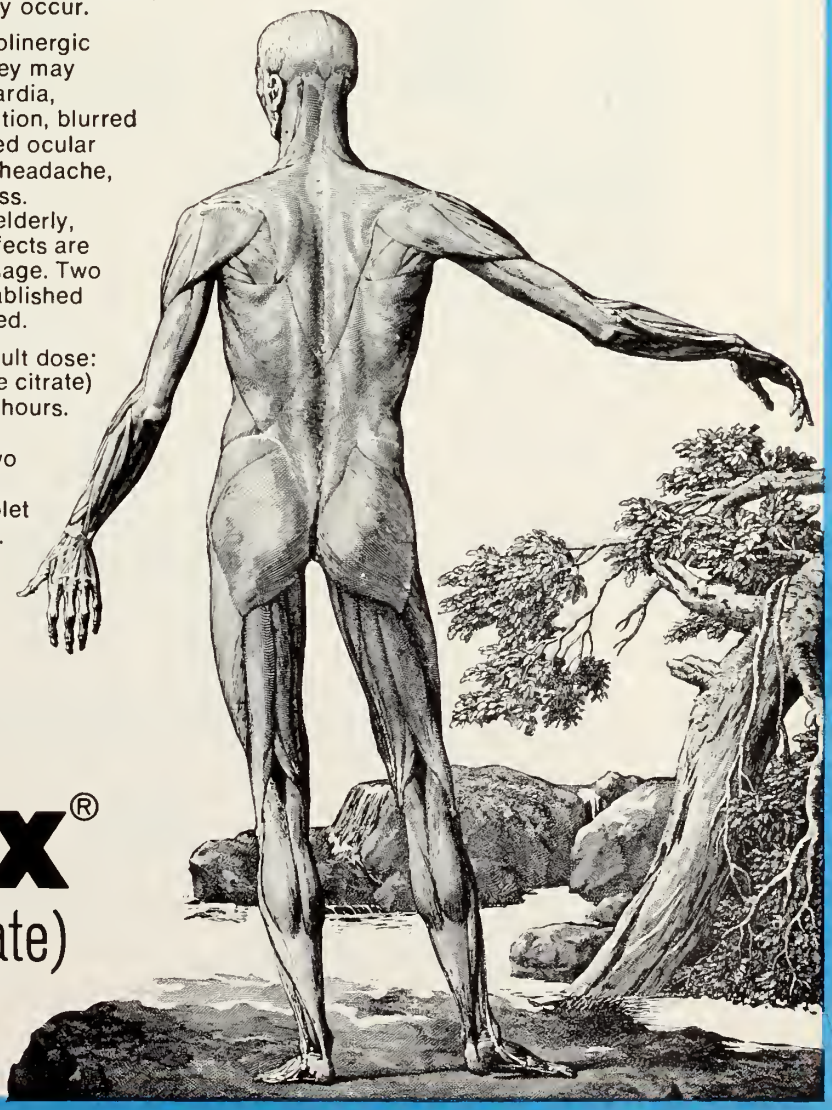
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it might be a good idea if you started losing some weight."*

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Obesity doesn't happen suddenly. This insidious process has its beginning—and the chances of reversing it are better—during the *first 10 to 15 pounds of weight gain.* When a new dietary pattern must be established, consider the adjunctive use of BAMADEX SEQUELS. Combining the proven *anorexigenic* action of d-amphetamine with the *tranquilizing* effect of meprobamate, BAMADEX SEQUELS controls appetite throughout the day, usually with a single capsule daily.

Contraindications: Dextro-amphetamine sulfate: In hyperexcitability and in agitated prepsychotic states. Previous allergic or idiosyncratic reactions to meprobamate.
Precautions: Use with caution in patients hypersensitive to sympathomimetic compounds, who have coronary or cardiovascular disease, or are severely hypertensive.

Dextro-amphetamine sulfate: Excessive use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised, especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on the drug. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of preexisting symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dosage and avoid operation of motor vehicles, machinery or other activity requiring alertness. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.
Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness. Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia; the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

Bamadex® Sequels®

Dextro-Amphetamine Sulfate (15 mg.) with Meprobamate (300 mg.) Sustained Release Capsules.

Lederle

LEDERLE LABORATORIES
A Division of American Cyanamid Company
Pearl River, New York

407-8



Disaster Medical Care Takes On New Significance

In these columns last month the Journal commented on the necessity for establishing a comprehensive program for handling a large number of patients in the event of a natural or man made disaster. The necessity is emphasized by receipt of a brochure published by the Ohio State Medical Association entitled "Emergency Medical Services During Civil Disturbances."

While Alabama has been extremely fortunate in escaping a serious civil disturbance, the experiences of other states could prove valuable. For this reason, we publish in its entirety the brochure of the Ohio State Medical Association on the assumption that it provides an excellent guideline for County Medical Societies in establishing Disaster Medical Care Programs whether the cause is rioting or some other catastrophic occurrence.

The text of the brochure follows:

The Committee on Disaster Medical Care of the Ohio State Medical Association urges that the component Medical Societies and their membership give serious consideration and planning to the special emergency medical and health services required during civil disturbances.

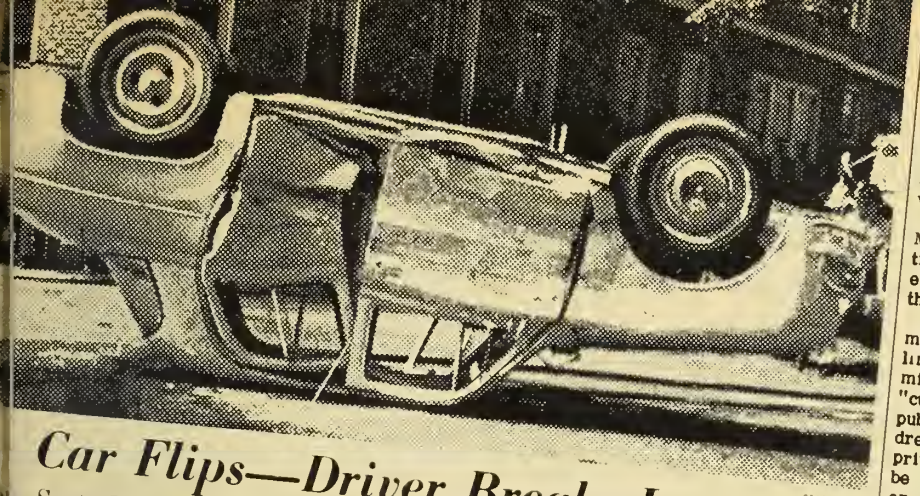
While recent experience suggests that these unfortunate community catastrophes do not place an undue burden on the treatment facilities or the medical care services of professional staffs of the involved hospitals, undisciplined emotions and convergence of law enforcement, military, and others involved, unfamiliar with health and medical procedures, may seriously hamper their performance. Since community planning frequently neglects to coordinate health and medical services with other emergency planning, the medical and allied health professions must assume early and effective leadership any joint effort to prepare for such community disturbances.

I. Emergency Health and Medical Services During Recent Civil Disturbances.

The more serious problems faced by health agencies during recent civil disturbances are attributed to the following:

1. Failure of identification of health personnel by police, national guardsmen, and other authorities.
2. Lack of adequate security services for the hospitals, environs, and street routes to these institutions.
3. Molestation of ambulances, their drivers, and attendants.
4. The need for segregation and care of prisoner patients under arrest.
5. Lack of continuing communications with police, ambulances, and other community agencies.
6. Lack of controlled access for visitors, clergy, and representatives of news media. Misrepresentation or fraudulent impersonation by extremist groups.
7. Unavailable delivery of short inventory supplies, blood, etc.

(Continued on Page 191)



Car Flips—Driver Breaks Leg

, Sept. 7. John P. Jones of
incurred a broken leg today
driving

Patrolman B. R. Brown, the car hit a fire hydrant and flipped over on its top
Hasn't he

STAFF PHOTO

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He's had enough excitement for one day.

For the patient who has been through an accident, the worry and anxiety following the experience may actually heighten the perception of pain. This is why there's a classic ¼ grain *sedative* dose of phenobarbital in Phenaphen with Codeine—*to take the nervous "edge" off,* so the rest of the formula can control the pain more effectively.

Phenaphen® with Codeine

Phenaphen® with Codeine No. 2, No. 3, or No. 4 contains: *Phenobarbital* (¼ gr.), 16.2 mg. (Warning: may be habit forming); Aspirin (2½ gr.), 162.0 mg.; Phenacetin (3 gr.), 194.0 mg.; Hyoscyamine sulfate, 0.031 mg.; Codeine Phosphate, ¼ gr. (No. 2), ½ gr. (No. 3), or 1 gr. (No. 4). (Warning: may be habit forming).

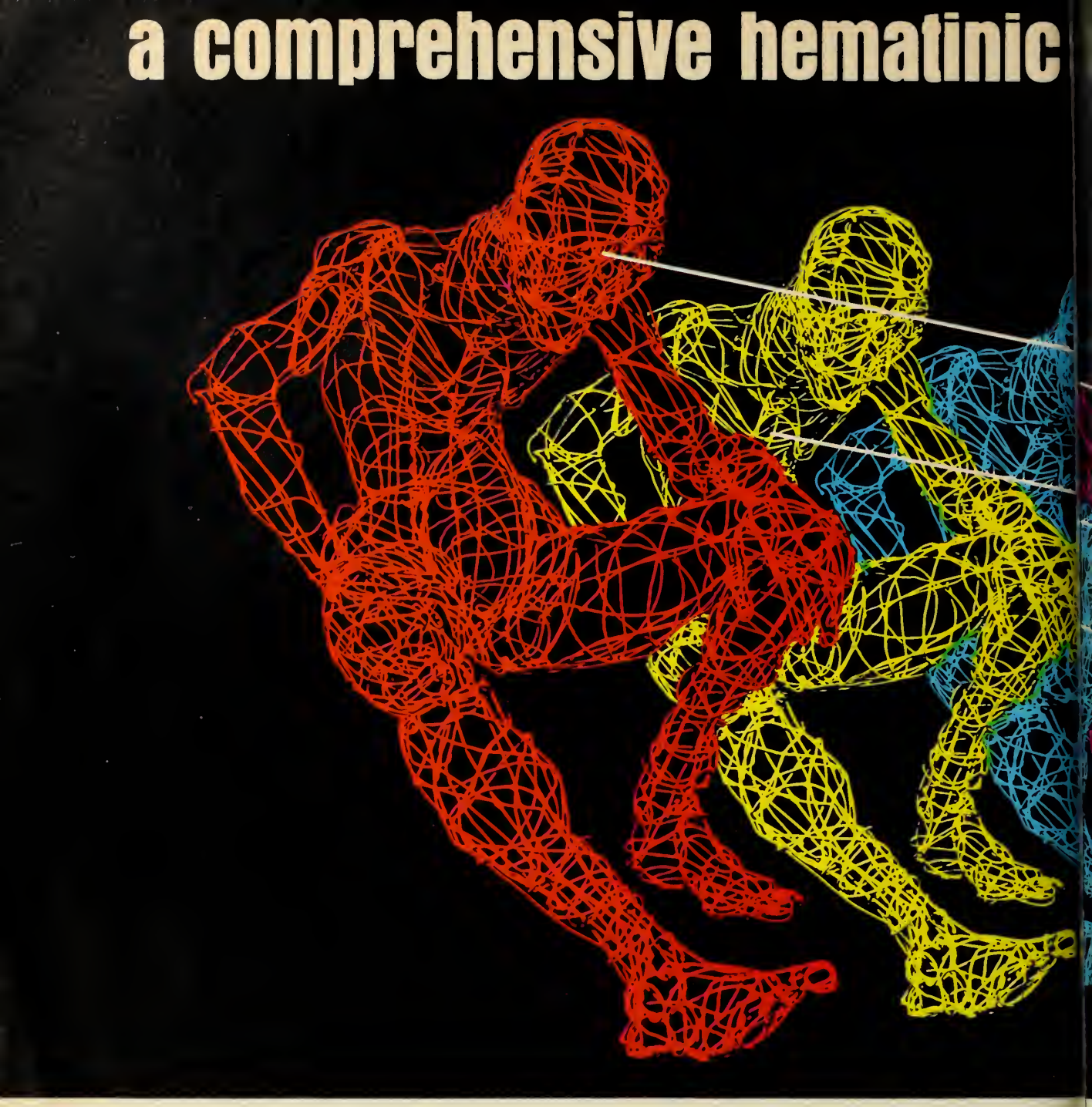
THE COMPOUND ANALGESIC THAT CALMS INSTEAD OF CAFFEINATES

Indications: Phenaphen with Codeine provides relief in severer grades of pain, on low codeine dosage, with minimal possibility of side effects. Its use frequently makes unnecessary the use of addicting narcotics. **Contraindications:** Hypersensitivity to any of the components. **Precautions:** As with all phenacetin-containing products excessive or prolonged use should be avoided. **Side effects:** Side effects are uncommon, although nausea, constipation and drowsiness may occur. **Dosage:** 1 or 2 capsules at 2 to 4 hour intervals, or as directed by physician. For further details see product literature.

A.H ROBINS COMPANY
RICHMOND, VA. 23220 A·H·ROBINS



a comprehensive hematinic



Description: Each Pulvule® contains—

Special Liver-Stomach Concentrate, Lilly (containing Intrinsic Factor)	150	mg.
Cobalamin Concentrate, N.F., equivalent to Cobalamin (The total vitamin B_{12} activity in the Special Liver-Stomach Concentrate, Lilly, and the Cobalamin Concentrate, N.F., is 15 micrograms.)	7.5	mcg.
Iron, Elemental (as Ferrous Fumarate)	110	mg.
Ascorbic Acid (Vitamin C)	75	mg.
Folic Acid	1	mg.

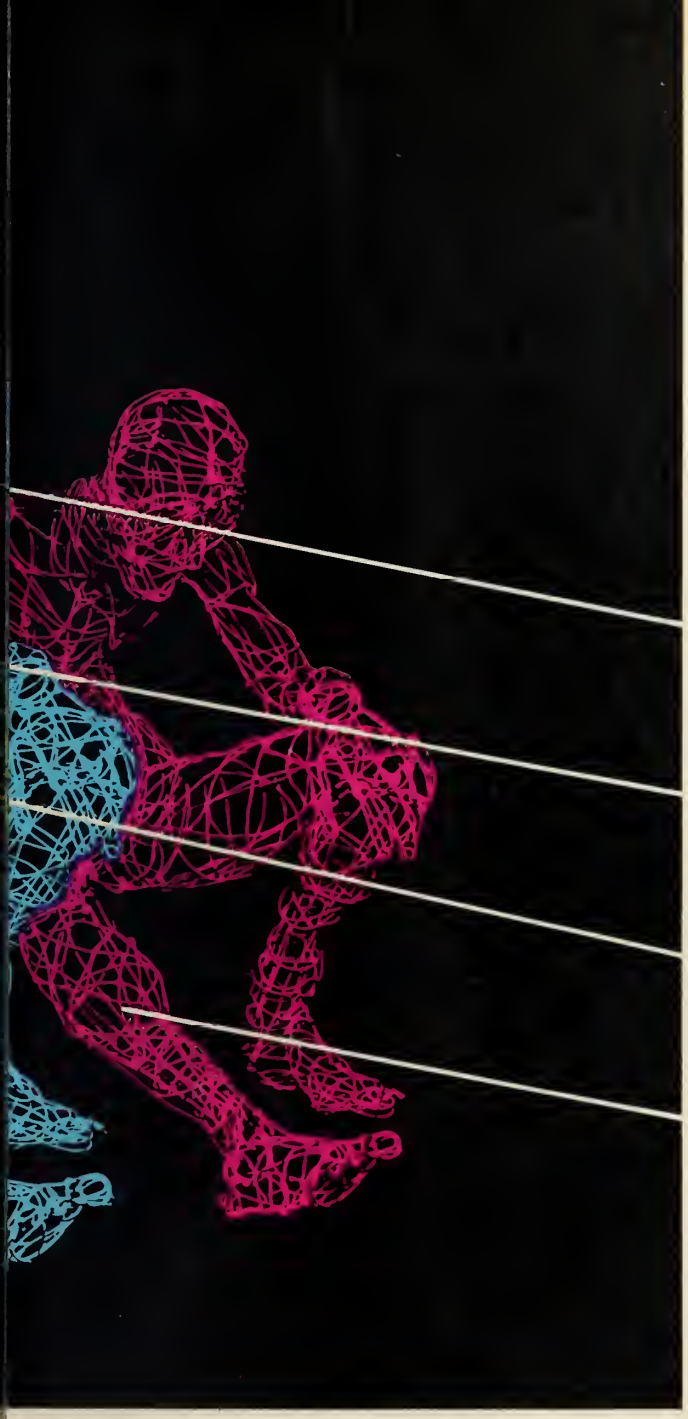
Indications: Trinsicon® (hematinic concentrate with intrinsic factor, Lilly) is a multifactor preparation effective in the treatment of anemias that respond to oral hematinics, including pernicious anemia and other megaloblastic anemias and also iron-deficiency anemia.

Contraindications: Hemochromatosis and hemosiderosis.

Precautions: Anemia is a manifestation that requires appropriate investigation to determine its cause or causes.

In pernicious anemia, the use of folic acid without adequate vitamin B_{12} therapy may result in hematologic remission but neurological progression. Adequate doses of vitamin B_{12} (parenteral or oral with potent intrinsic factor as in Trinsicon® [hematinic concentrate with intrinsic factor, Lilly]) usually prevent, halt, or improve the neurological changes.

As with all preparations containing intrinsic factor, resistance may develop in some cases of pernicious anemia to the potential tion of absorption of physiological doses of vitamin B_{12}. If resistance occurs, parenteral therapy, or oral therapy with so-called massive doses of vitamin B_{12}, may be necessary. No single regimen fits all cases, and the status of the patient observed in follow-up is the final criterion for adequacy of therapy. Periodi



You can treat combined deficiencies with

Trinsicon®

—the multifactor hematinic

Vitamin B_{12} plus intrinsic factor (15 mcg. B_{12} activity)—helps provide adequate levels of this important vitamin.

Folic acid (1 mg.)—treats nutritional macrocytic anemias and/or malabsorption syndromes.

Ascorbic acid (75 mg.)—augments the conversion of folic acid to its active form and helps iron absorption.

Iron (110 mg.)—treats hypochromic anemia.

clinical and laboratory studies are considered essential and are recommended.

Adverse Reactions: In rare instances, iron in therapeutic doses produces gastro-intestinal reactions, such as diarrhea or constipation. Reducing the dose and administering it with meals will minimize these effects.

In extremely rare instances, skin rash suggesting allergy has followed oral administration of liver-stomach material. Instances of apparent allergic sensitization have also been reported after oral administration of folic acid.

Dosage: One Pulvule twice a day. (Two Pulvules daily produce a standard response in the average uncomplicated case of pernicious anemia.)

How Supplied: Pulvules Trinsicon® (hematinic concentrate with intrinsic factor, Lilly), in bottles of 60 and 500. [032568]

Additional information available to physicians upon request.

Eli Lilly and Company, Indianapolis, Indiana 46206.

801668

Lilly

the antacid puzzle

In peptic ulcer:



solved by Mylanta®

aluminum and magnesium hydroxides *plus* simethicone

"will it ease the pain?"

Mylanta helps relieve ulcer pain with the two most widely prescribed antacids: aluminum and magnesium hydroxides.

will it help "my gassy stomach"?

Mylanta *also* contains simethicone: for concomitant relief of G.I. gas distress.

"will this one taste O.K.?"

The *prolonged* acceptance of Mylanta was recently confirmed in 87.5% of 104 patients—after a total of 20,459 documented days of therapy.* *Danhof, I. E.: Report on file.

Composition: Each Mylanta chewable tablet or teaspoonful (5 ml.) contains: magnesium hydroxide, 200 mg.; aluminum hydroxide, dried gel, 200 mg.; simethicone, 20 mg. *Dosage:* One or two tablets (well chewed or allowed to dissolve in the mouth) or one or two teaspoonfuls to be taken between meals and at bedtime.

Stuart Division/Pasadena, Calif.
ATLAS CHEMICAL INDUSTRIES, INC.

(Continued from Page 186)

8. The need to discontinue elective admissions and services.
9. Lack of accurate record keeping (type, cause, and location of wounds or injuries, salvage of bullets, violation of drug usage, patient remarks and mode of transportation to hospital, etc.)
10. Disorganized release of information to relatives and press.
11. Reluctance or indecision regarding activation of hospital disaster plan.
12. Lack of coordination of hospital services among several community institutions or lack of early assessment of demands to be made on individual hospitals.
13. Failure to establish protective maintenance of all hospital utilities and arrange for reserve utilities.
14. Physical protection of key areas from gun fire or assault by crowds.

Less serious, but equally important aspects of emergency medical services during such disturbances are:

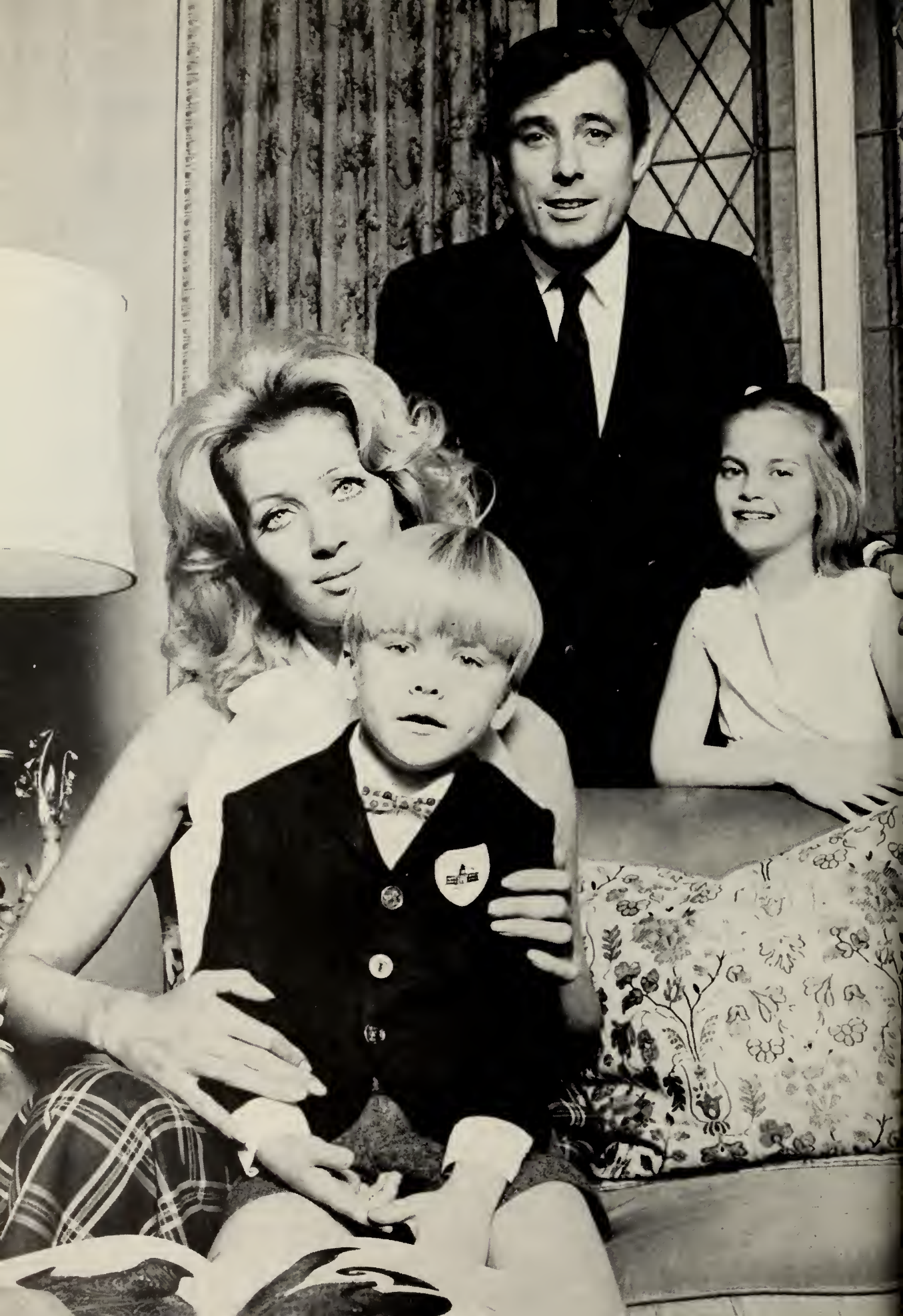
1. The need for adjustment of the emergency department to provide a continuous sorting process extending over a period of days.
2. The necessity for readjustment of the hospital disaster plan to provide long term continuing services.
3. The necessity for cancellation of elective surgical schedules.
4. The need to provide living quarters and food services for key personnel or those living at distance from institution.
5. The major influx of injured patients occurring during night time shifts.
6. The need for evacuation or transfer of patients from wards and special units.
7. The need to provide and arrange for emergencies unrelated to civil disturbances, both medical and surgical.
8. The need to establish new long term (4-7 days) duty and relief schedules for personnel generally not employed on shifts.
9. The need to establish one or more resuscitation units in or near the emergency department if not previously developed.
10. Delays in the disposition of ambulatory patients, and failure of followup.
11. Failure to review and brief hospital personnel on medical and legal responsibilities; i. e., insurance coverages, malpractice, communications to private attorneys, district attorney, etc.
12. Failure to establish arrangements with coroner or medical examiner regarding responsibilities and procedures for disposition of dead (next of kin, autopsies, etc.)
13. The lack of close cooperation and internal hospital communications between administration and professional personnel, particularly between the Chief of Medical Staff and the Administration.
14. The lack of equitable distribution of casualties among community hospitals.

II. Recommended Planning:

The Committee on Disaster Medical Care urges that local component medical societies, together with appropriate representation from allied health agencies and organizations in communities where civil disturbance may develop, establish a joint leadership (Council on Emergency Medical Services) to assess, plan and coordinate health and medical resources to the extent that the following evolves:

1. A coordination of emergency health and medical services with other emergency services and planning operations within the community.
2. The establishment of an Emergency Medical Operations Center for active

(Continued on Page 194)



pinworms
n this
amily?

possibly, because hygienic measures alone, however meticulous, may not prevent the spread of pinworm infections

REMINDER: Because pinworm infections spread easily and quickly in families, schools, and institutions, multiple infections in primary groups seem to be the rule rather than the exception. For successful management, it is desirable to check all exposed members of the family or play group. The *single-dose efficacy* of POVAN makes group therapy entirely practical, convenient, and economical.

INDICATION: Pinworm infection.

PRECAUTIONS: Tablets should be swallowed whole to avoid staining teeth. Pyrvinium pamoate will stain most materials. Stools may be colored red.

ADVERSE REACTIONS: Nausea, vomiting, cramping, and diarrhea have been reported.

POVAN is available in suspension or tablet form. The pleasant-tasting, strawberry-flavored suspension contains the pamoate equivalent of 10 mg. of pyrvinium base per cc., in 2-oz. bottles. The sugar-coated tablets each contain the pamoate equivalent of 50 mg. of pyrvinium base, bottles of 25.

...and if hygienic measures alone are not enough...?

when examination reveals pinworm infection, estimated to occur in from ⅓ to more than ½ of all American children from every social level, an increasing number of physicians favor treatment with a single, economical dose of—

Povan®
(pyrvinium pamoate)

PARKE, DAVIS & COMPANY, DETROIT, MICHIGAN 48232

PARKE-DAVIS

33668

(Continued from Page 191)

coordination of health agencies with themselves and other community emergency operations.

3. The assignment or establishment of casualty reception centers at hospitals selected by geographical location or emergency service capabilities; such units to be properly advertised to the community and suitably protected by adequate security at the hospital as well as access routes to the institutions.
4. The establishment of certain hospitals, properly advertised for management of ordinary or regular medical emergencies and health services.
5. The establishment of "back up" or support facilities for both types of hospitals described above.
6. The establishment of first aid or "forward" medical care units where indicated and time permits.
7. The establishment of an identification procedure for physicians and all health personnel.
8. The establishment of communications systems, traffic routes, and security services for ambulances.
9. The establishment of resupply procedures between hospitals and/or regular suppliers of blood, intravenous fluids, antibiotics and vaccines, etc.
10. A review and revision of hospital disaster plans and re-education or retraining of personnel as necessary.
11. The establishment of effective communications system (telephone hot lines, radio, etc.) between hospitals and community emergency operations center or Emergency Medical Operations Center.
12. The development of plans for evacuation of areas and wards nearest emergency departments and operation rooms within the hospitals.
13. The preparation of emergency entrances as only route of hospital entry.
14. The preparation of effective signs to properly identify areas of hospital operation, internal and external casualty routes, temporary visiting regulations, news information center for regular bulletins, etc.
15. The establishment of a prison ward.
16. The establishment of special medical care procedures for ambulatory and hospital patients. Review and re-familiarize professional staffs regarding management of all forms of trauma related to civil disturbance and policies established with reference to use of drugs, antibiotics, tetanus prophylaxis and management of shock, etc.

III. Summary:

The requirements for effective emergency, health, and medical services during civil disturbances have not been unique or stressful upon the health resources of a community. It is not a disaster in the usual sense and emergency departments or operating rooms are rarely taxed to the full capacities.

While a "build-up" or "incubation" period usually permits some preparation, a more leisurely planned and coordinated program with attention to the specific problems of these unfortunate human events can reduce the unusual mechanisms of interference with medical functions.

Emphasis in these emergency efforts should be related to the coordination with the overall community preparedness, to the establishment of an Emergency Medical Operations Center, to inter-ambulance and hospital communications, to security and protection for hospital and medical operations, to personal identification, procedures for health personnel, to the care for prisoner casualties and to the resupply program for continued hospital operations.

Is it depression?
She says "I'm always on edge..."



...but her other symptoms:
depressed mood, insomnia, anorexia, feelings of guilt
strongly suggest an underlying depression.

---

when the diagnosis is depression

ELAVIL® HCl
(AMITRIPTYLINE HCl | MSD)

Indications: Mental depression and mild anxiety accompanying depression.

Contraindications: Glaucoma and predisposition to urinary retention. Not recommended in pregnancy.

Precautions and Side Effects: Drowsiness may occur within the first few days of therapy. Patients should be warned against driving a car or operating machinery or appliances requiring alert attention. When depression is accompanied by anxiety or agitation too severe to be controlled by ELAVIL HCl alone, a phenothiazine tranquilizer may be given concomitantly. Suicide is always a possibility in mental depression and may remain until significant remission occurs. Supervise patients closely in case they may require hospitalization or concomitant electroshock therapy. Untoward reactions have been reported after the combined use of antidepressant agents having varying modes of activity. Accordingly, consider possibility of potentiation in combined use of antidepressants. Monoamine oxidase inhibitor drugs may potentiate other drugs and such potentiation may even cause death; permit at least two weeks to elapse between administration of two agents; in such patients, initiate therapy with ELAVIL HCl cautiously with gradual increase in dosage required to obtain a satisfactory response. Caution patients about errors of judgment due to change in mood, and that the response to alcohol may be potentiated. May provoke mania or hypomania in manic-depressive patients.

Side effects include drowsiness; dizziness; nausea; excitement; hypotension; fine tremor; jitteriness; weakness; headache; heartburn; anorexia; increased perspiration; incoordination; allergic-type reactions manifested by skin rash, swelling of face and tongue, itching; numbness and tingling of limbs, including peripheral neuropathy; activation of schizophrenia which may require phenothiazine tranquilizer therapy; epileptiform seizures in chronic schizophrenics; temporary confusion, disturbed concentration or, rarely, transient visual hallucinations on high doses; evidence of anticholinergic activity, such as tachycardia, dryness of the mouth, blurring of vision, urinary retention, constipation; paralytic ileus; jaundice; agranulocytosis.

Careful observation of all patients is recommended. The antidepressant activity may be evident within 3 or 4 days or may take as long as 30 days to develop adequately, and lack of response sometimes occurs. Response to medication will vary according to severity as well as type of depression present. Elderly patients and adolescents can often be managed on lower dosage levels.

Supplied: Tablets ELAVIL HCl, containing 10 mg., 25 mg., and 50 mg. amitriptyline HCl, bottles of 100 and 1000; Injection ELAVIL HCl, in 10-cc. vials, containing per cc.: 10 mg. amitriptyline HCl, 44 mg. dextrose, 1.5 mg. methylparaben, and 0.2 mg. propylparaben.

For more detailed information, consult your Merck Sharp & Dohme representative or see the package circular.

MERCK SHARP & DOHME Division of Merck & Co. Inc. West Point Pa 19486

WHERE TODAY'S THEORY IS TOMORROW'S THERAPY

Consider California's Problem

Alabama is beset with many problems relating to the health of the population. Fortunately, a major problem facing the Los Angeles County Medical Association is, as of this writing, not shared by Alabama. In a recent publication the Council of LACMA published the following protective measures which should be taken by the citizens of that area during severe smog conditions:

"a. Remain indoors whenever possible, especially from midmorning to midafternoon when the smog is usually the worst. Keep the doors and windows closed. Avoid dusts, smokes, fumes, sprays or other aerosols and particulates.

"b. Use an air conditioner if possible, and recirculate the air inside only. Do not draw outside air in during the day. The best units combine an absolute filter with the activated carbon unit and the air conditioner. Electrostatic units do not remove chemical smoke and are inferior to the activated carbon units.

"c. Obtain extra rest and sleep and avoid stimulating foods, drinks and medicines that increase metabolism. Avoid strenuous physical activity. Reduce to a minimum major cooking, cleaning and shopping activities.

"d. Cigarette smoking should be stopped completely, or at least be drastically reduced, as this further aggravates the respiratory problem. It would be best to stop all forms of smoking.

"e. Avoid driving the automobile if taking a depressant, tranquilizer or sedative drug. Avoid the freeways and sigalert conditions.

"f. Severe respiratory cripples living in smoggy areas should have facilities available for more intensive treatment. They should receive previous intensive treatment. They should receive previous instruction in the use of oxygen, bronchodilator drugs and respiratory assistance with intermittent positive pressure breathing devices.

"g. If the individual becomes distressed or dyspneic, the personal physician should be called.

"h. Most of the radio and television stations carry the Air Pollution Control District smog forecasts. Keep informed on the daily air pollution conditions."



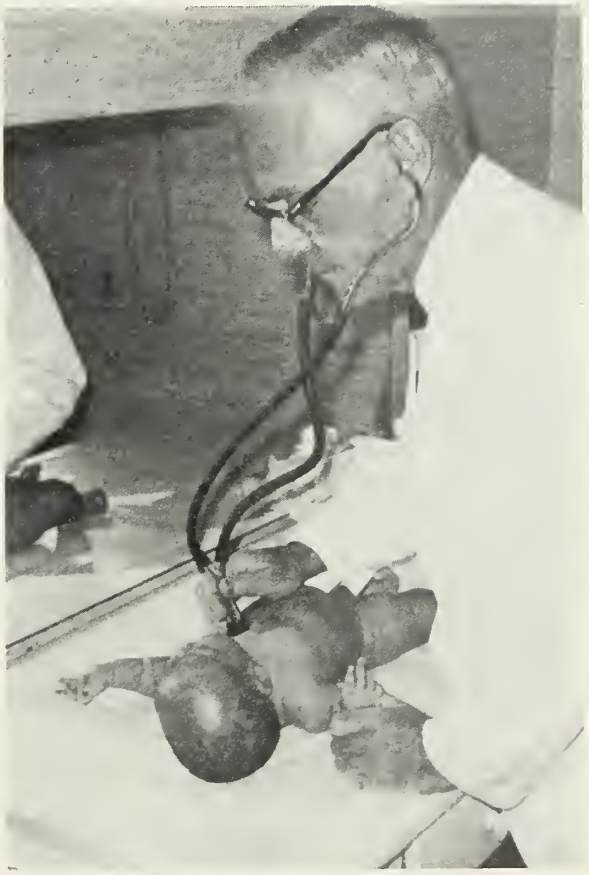
" . . . For Of Such Is The Kingdom"

Sixty years ago, when Dr. William Ross Britton was a child of 3, probably the most popular picture on the American scene was the sick bed of a child, the parents posed frantic and frightened, and the family physician leaning over the stricken infant.

Half a century after that, and Bill Britton could very well have been the doctor in a modern version of that celebrated picture. As a leading Montgomery pediatrician, any number of ailing infants were entrusted to his care.

It was not the baby who died in mid-July of this year . . . It was the doctor.

And the messages of grief, praise and appreciation that followed the announcement of his death, speak as eloquently in numbers as in content what the world around him thought of Bill Britton. Tributes ranged from the funeral sermon preached by his pastor, the Rev. Dr. Earl M. Hall, of Normandale Baptist Church, and the letter-to-the-editor of The Advertiser from Rex A. Turner, president of Alabama Christian College, to the flood of letters, notes and cards that went to his home and his office.



Dr. William Ross Britton

"He had the rare quality," one Mother wrote, "of treating his patients with the most modern methods, yet with the old fashioned touch of real concern and kindness."

Another wrote that, after moving to West Point, Georgia, it was reassuring "to know if we needed him, he was only 85 miles away. We shall always remember and be grateful for the many times he has helped make being a parent a little easier for us, for he not only gave the best medical attention to the baby, but comfort and compassion to frightened, worried parents."

There was a letter signed by a mother "for Faye, Patti, Kathy and Alan;" another signed by the patients themselves, "Dean, Louise and Melissa;" and one with the signature of a former patient who had grown up to become a Montgomery debutante, wife and mother, the parent of a new patient for Dr. Britton.

The image of the family doctor, at the bedside of a stricken child, vanished long ago from the art galleries and the wall displays of modern America. The pressures of overwork and specialization have completed what the telephone and the automobile, the laboratory and improved medical techniques began—what July's Journal called the "regretted de-personalization of the physician-patient relationship."

And who was this Montgomery pediatri-

cian whose life seemed a continuing contradiction of that comfortable generality?

Biographical essentials are well known: birthplace, Anniston; graduate Howard (now Samford), 1925, attended University of Alabama, and graduated Emory, 1929; moved to Montgomery in 1936, after internship in Chattanooga and New York hospitals and a year of practice in his native city; united two prominent Alabama Baptist families in his marriage to Margaret Mead; and survivors include two sons, William R. Britton, Jr., and Arthur Mead Britton; a granddaughter, Cathryn Mead Britton; a sister, Mrs. Charles Durgin, Anniston; and an older brother, Dr. James Woodruff Britton, member of the Baldwin County Medical Society, now practicing in Foley.

To the circles of friendship in which he moved, he was quiet and unassuming, probably a little timid, endowed with a touch of humor, always a pleasant and welcome member of society. To the religious community in general and to Alabama Baptists in particular, he was one who lived and practiced his faith, and who, with his father-in-law, Arthur Mitchell Mead, played a major part in building Baptist Hospital and its next-door adjunct, Meadhaven Nursing Home.

In letters of gratitude and praise, the families he served as a pediatrician voiced their assessment of him eloquently.

"Last November we almost lost our little girl, one of three children, with meningitis. Through many prayers and the constant care of Dr. Britton, she was spared. I wrote him a letter of appreciation after she came home from the hospital. Dr. Britton took the time out of a busy day to answer. Here's an excerpt:

" 'I have sometimes wondered why I continue in practice with all the heartaches, irregular hours, long hours, constant ringing of the phone, both at home and at the office, and screaming babies. Then I feel I have been well rewarded when I receive thoughtful letters such as you wrote. After all those little folks are really my life and I hope to continue treating them for many years to come.' "

Patients and their parents never suspected that screaming babies, ringing telephones, long and irregular hours, and heartaches ever upset him in the least. As one mother wrote from Calhoun, Ala.:

"I have called Dr. Britton many, many times, and no matter how many babies could be heard screaming in the background, his voice was always calm, soothing and unhurried. If you needed to call him at night or early morning, his voice never showed the faintest trace of annoyance. No matter how many sick children he had treated that day, he'd always stay at the office if they really needed him.

"He relieved many anxious parents on a great number of occasions, and for that we shall never forget him. . . Dr. Britton was more than a good doctor. He was one of the finest men I have ever known."

It was a further tribute to his two office assistants, Mrs. F. C. Madison and Mrs. Travis Dendy, that many letters from parents, patients and former patients went to the office and to them, not only from Montgomery but from a score of other towns and cities, among them Birmingham, Troy, Greenville, Tuskegee, Union Springs, Prattville, Wetumpka, Eufaula, Atmore, Clanton, Andalusia, Pine Apple, Dadeville, Auburn and Opelika. Among them was the letter from the former Montgomery debutante which went to his office, and whose mother had written a terse letter-to-the-editor, which was published:

"Montgomery has suffered a great loss in the passing of Dr. William Britton. His love and compassion for his patients made him the kind of doctor all others should strive to be. We will miss him."

Abbott Antihypertensive Building Blocks

A simplified approach to the practical management of hypertension



Enduron: (methyclothiazide) A basic building block for mild hypertensives



Excellent day-long Na^+ output, yet easy on the K^+

Enduron provides an excellent starting therapy. Your patient's sodium excretion is greatly enhanced. Yet potassium loss is low.

The therapeutic action is smooth, and persists for a full 24 hours. With Enduron you can prescribe convenient once-a-day dosage without skimping your patients on day-long thiazide effectiveness.

Of course, as with all thiazides, supplemental dietary potassium should also be considered.

Use Enduron as a basic therapy in patients with mild to moderate hypertension. A single 5-mg. tablet each day is ample in most cases.

Once a day, every day

ENDURON

METHYCLOTHIAZIDE

MILD TO MODERATE TO SEVERE



See Brief Summary on final page of advertisement

Enduronyl: Its deserpidine component adds response in moderate hypertension



Less frequent rauwolfia side effects than with reserpine

When you wish to build further response, consider shifting to Enduronyl.

Enduronyl adds a building block of *deserpidine*. This is a purified rauwolfia alkaloid available only from Abbott. It adds good antihypertensive and tranquilizing activity. Yet its incidence of untoward effects, particularly lethargy and depression, is lower than with reserpine.

Enduronyl is available plain or Forte. The latter provides its variation where most helpful, by doubling the deserpidine.

Use Enduronyl for patients throughout the broad range of mild to moderately severe hypertension.

Once a day, every day

ENDURONYL®

METHYCLOTHIAZIDE 5 mg. with DESERPIDINE 0.25 mg. or (FORTE) 0.5 mg.

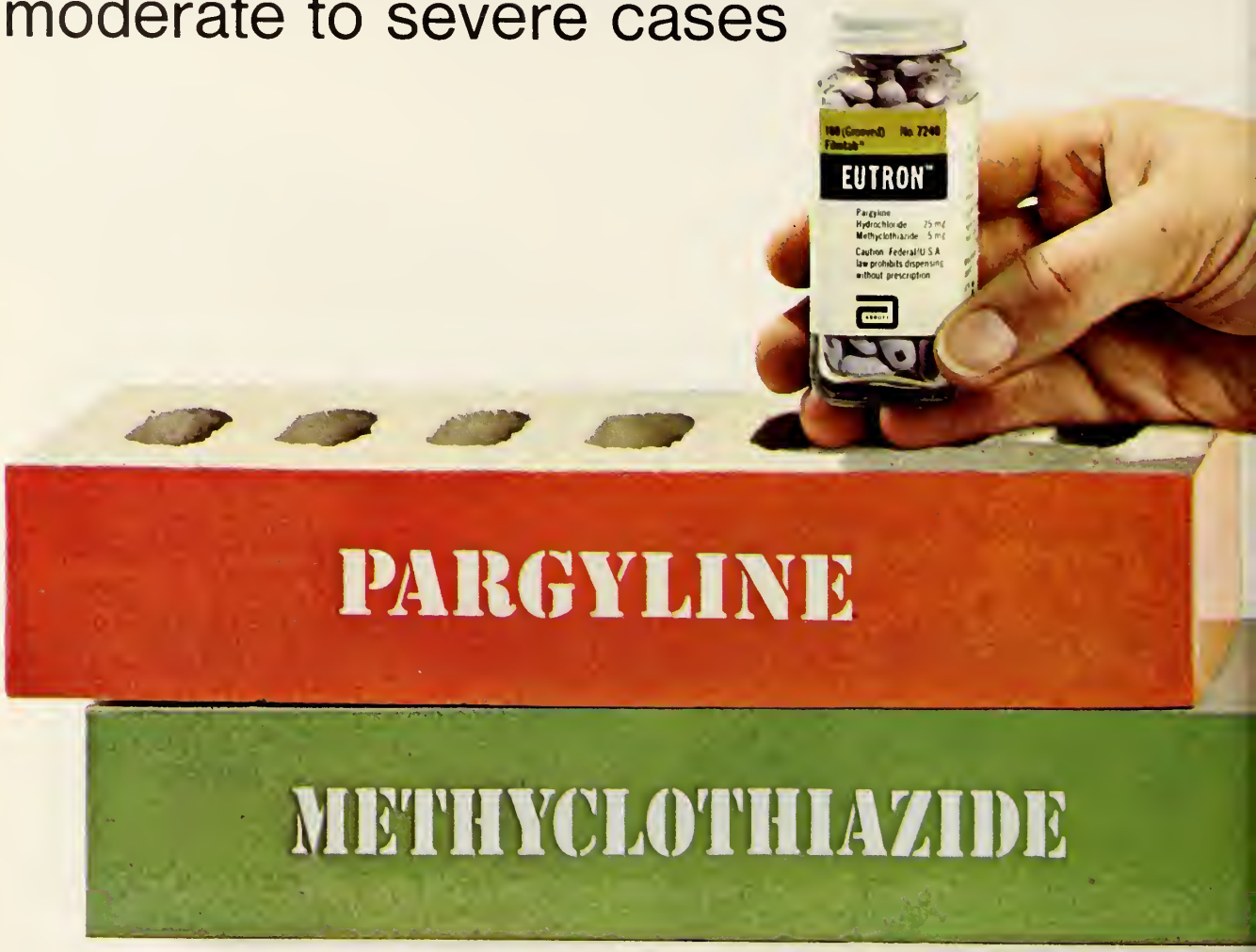
MILD TO MODERATE TO SEVERE



See Brief Summary on final page of advertisement

801094

Eutron: A unique combination for handling moderate to severe cases



Affords almost uniform diastolic reduction in all body positions

Eutron lowers diastolic pressures nearly equally, whether your patient is standing up or lying down.

Thus, in clinical trials, average *standing* diastolic readings were reduced from 112 pre-treatment to 90 post-treatment; *sitting* from 115 to 95; and *recumbent* from 112 to 94.

Note that following Eutron, the diastolic reductions were nearly alike in all three body positions.

Use Eutron for managing your moderate to severe cases. Its building blocks enhance each other; hence lesser doses often suffice.

Once a day, every day

EUTRON™

PARGYLINE HYDROCHLORIDE 25 mg.
with METHYCLOTHIAZIDE 5 mg.

MILD TO MODERATE TO SEVERE



See Brief Summary on final page of advertisement

ENDURON® | ENDURONYL®

METHYCLOTHIAZIDE

Each tablet contains
Methyclothiazide 5 mg. with
Deserpidine 0.25 mg. or 0.5 mg.

Indications: Edema and mild to moderate hypertension (Enduron), and mild to moderately severe hypertension (Enduronyl). More potent agents, if added, can be given at reduced dosage.

Contraindications: Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease or impending hepatic coma (hepatic coma due to hypokalemia has been reported in patients on thiazides). Do not use Enduronyl in severe mental depression, suicidal tendencies, active peptic ulcer, or ulcerative colitis.

Warnings: Consider possible sensitivity where there is history of allergy or asthma. If added potassium is indicated, dietary supplementation is recommended. Reserve enteric-coated potassium tablets for cautious use only when necessary, as they may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation often requiring surgery; discontinue them immediately if abdominal pain, distention, nausea, vomiting, or g.i. bleeding occurs. Neither Enduron nor Enduronyl contains added potassium.

Precautions: Use thiazides cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery, thiazides may reduce response to vasopressors, and increase response to tubocurarine. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia) in all patients. In hypokalemia (especially in digitalized patients) give supplemental potassium. In hypochloremic alkalosis, give supplemental chloride.

Use rauwolfias with caution in patients with history of peptic ulcer. Rauwolfias with anesthetics may produce hypotension and bradycardia. Discontinue Enduronyl two weeks before elective surgery. Consider vagal blocking agents during emergency surgery. In epilepsy, adjust anticonvulsant dosage. In electroshock, shorten stimulus strength and duration. In occasional patients with depressive tendencies, rauwolfias may precipitate severe mental depression that usually disappears when drug is stopped.

Adverse Reactions: Thiazide reaction include blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, serum uric acid or blood sugar; anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, symtomatic gout, and pancreatitis. Cutaneous vasculitis in the elderly has been reported with other thiazides. Adverse effects with deserpidine are qualitatively similar to those with reserpine, but their incidence is lower. These include nasal stuffiness, abdominal cramps or diarrhea, nausea, headache, weight gain, reduced libido and potency, peptic ulcer aggravation, epistaxis, skin eruption, asthma in susceptible patients, electrolyte imbalance, excessive salivation, and a reversible Parkinson's syndrome. Excessive drowsiness, fatigue, weakness, and nightmares may signal mental depression. Thrombocytopenia, purpura, and a symptom manifested by dull sensorium, deafness, uveitis, glaucoma, and optic atrophy are rare allergic reactions to other rauwolfias. Hypotension from antihypertensive agents may precipitate angina attacks in susceptible individuals. Usually adverse reactions disappear when drug is withdrawn.

EUTRON™

Each tablet contains
Pargyline Hydrochloride 25 mg.
with Methyclothiazide 5 mg.

Indications—Moderate to severe hypertension.

Contraindications—Pheochromocytoma, paranoid schizophrenia, hyperthyroidism and advanced renal failure. Not recommended in malignant hypertension, children under 12, pregnant patients.

Do not use with: centrally or peripherally acting sympathomimetic drugs; foods high in tyramine (e.g., aged and natural cheeses); parenteral reserpine or guanethidine; imipramine, amitriptyline, desipramine, nortriptyline or their analogues; other monoamine oxidase inhibitors; methyldopa or dopamine; separate Eutron and these agents by two weeks.

Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease; impending hepatic coma from thiazide-induced hypokalemia.

Warnings—Patients: 1. No other drugs (particularly "cold preparations" and antihistamines), cheese or alcohol without physician's consent. 2. Promptly report orthostatic symptoms, severe headache, other unusual symptoms. 3. Angina pectoris or coronary artery disease patients must not increase physical activity with improved anginal symptoms or well-being.

Physicians: 1. Use antihistamines, hypnotics, sedatives, tranquilizers and narcotics (meperidine contraindicated) cautiously in reduced doses. 2. Stop Eutron two or more weeks before elective surgery; in emergency surgery reduce premedication (narcotics, sedatives, analgesics, etc.) to 1/4 to 1/5; carefully adjust anesthetic dosage to patient response. 3. Use cautiously in advanced renal failure. 4. Pargyline may induce hypoglycemia. 5. Consider possible sensitivity reactions when a history of allergy or asthma is present. 6. If potassium is indicated, dietary supplement is recommended; enteric-coated potassium tablets may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation frequently requiring surgery; discontinue medication immediately if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs; Eutron does not contain added potassium. 7. Possible systemic lupus erythematosus has been reported for thiazides.

Precautions—Pargyline: Use cautiously at reduced dosage: caffeine, alcohol, antihistamines, barbiturates, chloral hydrate, other hypnotics, sedatives, tranquilizers, narcotics. Periodically do urinalyses, blood counts, liver function tests, etc. Use with caution in liver disease. Watch for orthostatic hypotension, especially in impaired circulation (e.g., angina pectoris, coronary artery disease, cerebral arteriosclerosis); also, augmented hypotension in concomitant febrile illnesses. Reduce or discontinue if hypotension is severe. In impaired renal function watch for cumulative drug effects, elevated BUN and other evidence of progressive renal failure; withdraw drug if these persist. In surgery increased central depressant response (hypotension and increased sedative effect) can be controlled by (1) discontinuing at least two weeks prior; (2) in emergency surgery lowering dose of premedication; (3) when necessary, administering a vasopressor. Do not use in hyperactive and hyperexcitable patients. Pargyline may unmask severe psychotic symptoms where emotional problems pre-exist. Use cautiously in Parkinsonism, especially with antiparkinsonian agents. In prolonged therapy, examine for change in color perception, visual fields, fundi and visual acuity. Also, prolonged therapy has made certain patients refractory to nerve blocking effects of local anesthetics.

Methyclothiazide: Use cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery thiazide may reduce vasopressor response and increase tubocurarine response. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia). Give supplemental chloride if hypochloremic alkalosis occurs and supplemental potassium if hypokalemia occurs (especially in digitalized patients). Thiazides may decrease serum P.B.I. without signs of thyroid disturbance.

Adverse Reactions—Pargyline: Orthostatic hypotension and associated symptoms, mild constipation, fluid retention, edema, dry mouth, sweating, increased appetite, arthralgia, nausea, vomiting, headache, insomnia, difficult in micturition, nightmares, impotence, delayed ejaculation, rash, purpura, weight gain, hyperexcitability, increased neuromuscular activity and other extrapyramidal symptoms. Drug fever is extremely rare. Reduction in blood sugar and hypoglycemic effects are possible. Congestive heart failure has been reported in a few patients with reduced cardiac reserve.

Methyclothiazide: Blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, blood sugar or serum uric acid (gout may be induced); anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice and pancreatitis. Cutaneous vasculitis in elderly patients has been reported with other thiazides.

If side effects are severe or persist, reduce dosage or withdraw drug. 804438R

ABBOTT

TM-TRADEMARK

PHYSICIAN PLACEMENT SERVICE IN ALABAMA

The Physician Placement Service of the Medical Association of the State of Alabama is designed to assist both physicians and communities. MASA members having knowledge of practice opportunities or wishing to relocate their own practices are urged to communicate with the Placement Service. For further information: write Mr. Emmett Wyatt, Executive Assistant, Medical Association of the State of Alabama, 19 South Jackson Street, Montgomery, Alabama 36104, or Telephone 263-6441.

Locations Wanted

Anesthesiology—

Age 37; University of Pittsburgh, 1957; seeking group or associate practice. Available October 1968. LW-334

General Practice—

Age 27; Louisiana State University 1967; seeking group or associate practice. Available August 1968. LW-335

Age 38; University of Oklahoma, 1955; seeking associate, institutional or industrial practice; in town of 10,000 plus population; interest in surgery. LW-336

Age 28; University of Tennessee, 1965; available November 1968. LW-337

Age 28; Medical College of Alabama 1966; seeking practice in town of less than 14,000 population to fulfill scholarship requirements. Available 1968. LW-338

Age 52; University of Chicago 1950; seeking group, industrial, institutional or student health position. LW-339

Age 56; Georgetown University 1938; seeking solo, group or associate practice, with general surgery. Available July 1968. LW-340

Internal Medicine—

Age 34; Hahnemann Medical College 1959; Board eligible, National Board; seeking solo, group, or associate practice. Available immediately. LW-342

Age 34; University of Tennessee, 1958; American Board Certified, seeking group, industrial, or institutional practice. Available Spring 1968. LW-343

Age 32; University of Louisville 1965; seeking associate or group practice in city of approximately 50,000 population. Available July 1969. LW-343/1

Neurology—

Age 31; Harvard 1962; Board eligible; National Board; seeking solo, group or associate practice. Available July 1969. LW-344

Age 30; Medical College of Alabama 1962; Board eligible; National Board; seeking solo, group, associate or institutional practice. Available January 1969. LW-345

Obstetrics-Gynecology—

Age 35; Vanderbilt University 1950; Board eligible; Available July 1968. LW-346

Age 37; University of Virginia 1959; Board certified; seeking group or associate practice. Available September 1968. LW-347

Age 34; University of Missouri 1959; Board certified; seeking group, industrial, associate or institutional practice. Available July 1968. LW-348

Age 36; Medical College of Alabama 1957; Board eligible; seeking group or associate practice. Available immediately. LW-348-A

Radiology—

Age 31; S. U. N. Y. College of Medicine, 1961; Board eligible; seeking solo, group, or associate practice. LW-350

Age 41; Cornell Univ. Medical School, 1953; Board certified; seeking group, or associate practice. Available immediately. LW-351

Age 51; Univ. of Texas Med. Branch, 1942; Board certified; seeking solo, group, or associate practice. LW-352

Surgery—

Age 33; University of Missouri, 1961; seeking group or associate practice. Available January 1969. LW-353

Age 38; Emory University, 1956; Board eligible; seeking group, associate, or institutional practice. Available July 1968. LW-354

Age 37; Faculty of Medicine, Manitoba, 1957; Board certified; seeking associate or institutional practice. Available July 1968. LW-355

Age 34; Board eligible; University of Santo Tomas, 1961; seeking group or associate practice. Available July 1968. LW-356

Age 35; Board eligible; Univ. of Santo Tomas, 1956; seeking solo, group, industrial or associate or institutional practice with general practice. Available immediately. LW-357

• • •

Physicians Wanted

General Practitioners—

For town in South Alabama with 20,000 trade area, within 40 miles of Gulf beaches and large city. Excellent hunting and fishing. Numerous industries offering stable employment for area. Furnished office available rent free. Hospital presently engaged in complete remodeling and expansion. PW-212

For town of 4,500 population in trade area of 10,000 to 15,000 with annual payroll of 4½ million dollars, located in north central Alabama. Within 75 and 85 miles respectively of two metropolitan areas with combined population of 2 million. Hospital privileges available in modern 30-bed hospital. A modern 40-bed extended care facility adjoins hospital. Excellent churches, schools and shopping areas. In the center of the best hunting, fishing and recreational area in the state. PW-212/1

PHYSICIANS WANTED

(Continued)

Physician wanted to join well established partnership in Northwest Alabama city of 15,000 population. Two accredited hospitals, junior college, schools, churches, recreational activities. No obstetrics or surgery. New office building. PW-212/2

For city of approximately 15,000 population in north Alabama, with trade area of approximately 45,000 population. Hospital with over 100 beds, and expansion planned for next year. Nursing homes in the area. Industrial growth and agricultural region. Several churches and schools. Golf course, civic and fraternal organizations. PW-212/3

Unusual opportunity for two general practitioners with military obligations satisfied at a modern fifty bed facility located 15 minutes drive from largest metropolitan center in north-central Alabama. Construction of a new two-story office building is scheduled to begin soon. PW-213

Opportunity in rapidly expanding community of 10,000-12,000 population adjacent to metropolitan center in north Alabama. Office space free for six months and equipment available. Staff privileges at nearby hospitals. PW-214

For town of 3,600 population in trade area of 5,000-7,000 within 100 miles of two large cities and the Gulf Coast. 50-bed hospital located in the town. Office space available. Agricultural and expanding industrial area. Several churches and two schools. Recreational activities in the town as well as nearby—golf course, hunting and fishing. PW-215

For town of approximately 1,000 population in North-central Alabama in trade area of 12,000 population. 100-bed hospital in adjoining city. PW-216

For town of 12,500 population in trade area of 50,000 located in South Alabama. Nearest large city with population of 145,000 is 80 miles. One of the physicians died recently. Two hospitals with 140 beds. Numerous small industries; several churches and schools. Recreational activities include water sports and golf course. PW-217

For town of approximately 1,000 population in population center of 10,000 located in Southwest Alabama within 90 miles of the Gulf coast. City owned clinic is offered rent free and fully equipped. Hospitals are located in two nearby towns within 25 miles. This is principally an agricultural region, but there are military installations nearby. Numerous civic clubs, community concert series, and a country club offer recreational activities. PW-218

For town with 1,000 population in trade area of 5,000 Southeast Alabama. Nearest large city with population of 50,000 is 55 miles. New clinic available rent free. No physicians in the town. Hospitals in surrounding town within 30 miles. Several churches and schools. PW-219

Opportunity in city of 5,000 population located in Northeast Alabama in trade area of approximately 10,000 population. Office space available. One physician died recently. Hospital and nursing home in the city. PW-220

For town of 1,000 plus population in west-central Alabama in trade area of 20,000. Clinic available. Nearest city of approximately 70,000 population is located a distance of 17 miles. Farming, cattle, timber, and manufacturing plants are principal resources of the area. Churches, schools, and recreational advantages. PW-221

For solo practice in town of approximately 17,000 population located in east central Alabama. 48-bed general hospital. Arrangements available for office space. Excellent recreational advantages which include hunting, fishing and water sports. City owned airport. Numerous civic clubs. Excellent schools and churches. Expanding industrial and agricultural area. PW-222

Opportunity for one or more doctors in rapidly expanding eastern suburb of Birmingham. Attractive brick building consisting of 10 rooms and adjacent parking facilities. PW-223

Opportunity for general practitioner to join a five-man group, practicing as a partnership. Each man in the group is either specialized or semi-specialized. The practice is physically located within a 70-bed hospital. Willing to pay qualified person $36,000 for the first year, with possible partnership status in one year. Would consider a physician for locum tenens for three to six months at $2,000 per month. PW-224

Opportunity in centrally located town in North Alabama in trade area of 10,000-15,000 population. The only doctor is retiring. Housing and office space readily available. Churches and schools. Recreational advantages of nearby lakes. PW-225

Surgeon—

Opportunity for a Board eligible or Certified surgeon to practice in city of over 78,000 population in north Alabama. Equipment available. PW-226

Special Openings

Specialist in the following fields: Internal Medicine, Pediatrics, Obstetrics-Gynecology and General Practitioners. 58 bed fully accredited general hospital with 91 bed addition to be completed in July 1968. Modern new office space available. PW-227

Medical Superintendent of 225 bed tuberculosis sanatorium with a building program in Birmingham. Salary and job description negotiable. Must be able to obtain Alabama license. PW-228

Physician interested in Internal Medicine and Chest Diseases to provide general medical services in 184 bed Tuberculosis Hospital in North Alabama. References and experience data required in advance. U. S. citizens and fully licensed physicians given first choice. Others will be considered upon request. Salary open. PW-229

SMV Emblem Developed

Have you ever been forced to brake suddenly in order to avoid a collision with a slow-moving vehicle (SMV) on the highway? Statistics indicate that the majority of us have experienced just such an incident. Often a motorist is unable to recognize a SMV until it is too late to prevent an accident, which can result in serious injuries or fatalities and considerable property damage.

Studies have shown that collisions involving SMV's with other vehicles are a 24-hour-a-day problem, which is faced 365 days a year. Furthermore, it has been established that these accidents occur mostly on good open highways, during daylight hours in nice weather, and without the motorist's view being obstructed.

The Ohio State University, which has done extensive research in this area of grave concern, has developed the "SMV Emblem" to aid in the identification of vehicles with speed capabilities of less than 25 miles per hour—such as farm tractors, road maintenance equipment, construction equipment and horse-drawn vehicles. The SMV emblem is a 14-inch equilateral triangle with a fluorescent orange center for daytime visability and a reflective red border for nighttime. If properly mounted on the center rear of a vehicle, two to six feet above ground, it will be visible and identifiable both day and night from a distance of 500 feet or more.

The Board of Directors of the National Safety Council approved a policy statement regarding the SMV emblem, and the American Society of Agricultural Engineers and the Society of Automotive Engineers were responsible for the development of specifications for the physical properties, dimensions, component materials and use of the emblem.

The American Medical Association's Board of Trustees and the Council on Rural Health, recognizing the fact that widespread adoption and utilization of the Slow-Moving Vehicle Emblem could prevent numerous accidents and greatly reduce the toll of disability and death on the highways, urged the AMA House of Delegates to approve the following recommendations:

"1. That the AMA officially endorse the SMV emblem and the objectives for which it stands, and commend the American Society of Agricultural Engineers, the Ohio State University and the National Safety Council for the development of the idea and their assistance in its implementation.

"2. That the AMA, in cooperation with state and county medical societies, promote the use of the SMV emblem on slow-moving vehicles and help to educate the public to recognize it as identifying these vehicles."

These recommendations were formally presented to the AMA House of Delegates during its Annual Convention in San Francisco, California, and officially adopted on June 19, 1968.

Additional steps have been taken in that as of April, 1968, nine states had passed legislation with regard to the use of the emblem. Approximately nine more states are expected to introduce similar legislation during the remainder of 1968. While progress is being made, increased emphasis is required in order to secure national adoption and utilization of the SMV emblem.

Those interested in obtaining additional pertinent details regarding the Slow-Moving Vehicle Emblem may do so by contacting either Mr. Leon J. Urben, Director of the Farm Department of the National Safety Council, 425 Michigan Avenue, Chicago, Illinois 60611; or the American Medical Association's Council on Rural Health, 535 North Dearborn Street, Chicago, Illinois 60610.

A Workshop on Marriage

A three-day Workshop on Marriage and Family Counseling will begin in Birmingham on Tuesday, Oct. 22nd, sponsored by the Episcopal Diocese of Alabama and the Alabama Association for Mental Health.

Three members of the workshop staff, from the American Institute of Family Relations in Los Angeles, Calif., will read papers and lead panel discussions. They are:

Clinton E. Phillips, Ph. D., Director, Department of Counseling and Director of Summer Workshop, AIFR, president of Southern California Association of Marriage Counselors, and co-author of "What Marriage Counselors Should Know About Heredity" and "Guide for Premarriage Counseling;"

Mary Jane Hungerford, Ph. D., Director of Department of Education, AIFR, vice president of California State Association of Marriage Counselors, president Childbirth Education Association of Los Angeles;

Donald P. Wilson, Ph. D., Director, Department of Research, AIFR, consultant in private practice; formerly Psychologist, U. S. Public Health Service, assigned to Fort Leavenworth; senior Psychologist, 9th Service Command, U. S. Army; professor of Psychology, Los Angeles State College; chairman Department of Psychology, University of Redlands; author of best-seller "My Six Convicts," and co-author, "Psychological Factors in Marital Happiness."

Lecture and discussion subjects for the three-day workshop will range from the techniques of counseling to helping the depressed client, from counseling goals and the merits of counseling together or separately to the sexually unsuccessful and the hostile client and the hostile counselor. Panels and lectures will be with open discussions, questions and answers, and a motion picture in color.

The Workshop will be held in St. Luke's Parish Hall, where luncheon will be served each of the three days. The registration fee of $25 includes the cost of luncheon, and checks made payable to Marriage & Family Counseling Workshop, accompanied by the name and address of the registrant, are to be sent to Lowell S. Hamilton, P. O. Box 3283, Birmingham, Ala. 35205.

Practical Aspects Of Respiratory Care And Pulmonary Rehabilitation

The Division of Continuing Medical Education, Medical College of Alabama, will again conduct a special workshop in respiratory care from October 13th through October 17th. The workshop has been designed for teams consisting of a physician and a nurse, therapist, or technician working together. In addition, arrangements are such that these individuals are trained on the same type of equipment available in the registrants' own medical facility.

This year the program will consist of two days at the Ann Jordan Lodge and two days in Birmingham. The registration fee for each person will be $100.00.

Although preference will be given to teams of physicians and technical personnel, applications will also be considered from physicians and technicians or nurses individually. The total number of registrants will be limited and prompt application is advisable.

Address your letter of application to:

Dr. Margaret S. Klapper, Director
Division of Continuing Medical Education
1919 Seventh Avenue, South
Birmingham, Alabama 35233



Now...twice as much as before in each teaspoon

400,000 units of potassium penicillin V per teaspoonful

New...V-Cillin K®, Pediatric, 250 mg.

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A Double-Blind Evaluation of Tenuate Dospan in Overweight Patients from a Private Gynecologic Practice

by

O. Thomas Bolding, M. D.

Birmingham, Alabama

Introduction

It has been estimated that up to 60 per cent of the population of the United States is overweight or has been overweight at one time or another. Attempts to solve this problem have been made by investigators from different clinics throughout the United States. They have offered regimens ranging from the high fat diet to the popcorn diet, but, unfortunately, no uniform agreement offering a measurable amount of success has been found.

It is our feeling that the only thing that is important in a diet program is the curtailment of calories. This can be accomplished either by fortifying the patient with a psychologic motivation to curtail calories without the benefit of a drug or by thoroughly discussing the problem with the patient, placing him on a restricted caloric intake, and offering him an anorexic drug to curb the appetite until he is able to change his eating habits. In our practice we have found the latter method to be more successful.

Diethylpropion hydrochloride has been reported to be an effective anorexic.[1-6] In order to confirm its effectiveness, a double-blind study of the 75 mg. continuous release formulation (Tenuate* Dospan*) was initiated in our office practice.

Methods

Fifty-two patients, 15 to 56 years old, who were at least 20 per cent overweight according to age and height and who were interested in losing weight were selected for a 12-week study. After weight and blood pressure were recorded, Tenuate Dospan or an identical-appearing placebo was randomly distributed in coded bottles; a table of random numbers was used for coding. Neither the

*Registered trademarks of The Wm. S. Merrell Company, Division of Richardson-Merrell Inc., Cincinnati, Ohio.

patient nor the investigator knew which medication was being taken. The patients were instructed to take one tablet in mid-morning, to follow a 1000-calorie diet, and to continue any other medication then being prescribed.

At each weekly office visit, blood pressure and weight in street clothes, without shoes, were recorded. Patients were questioned specifically concerning side effects.

Results

When the code was broken at the end of the study, it was found that 27 patients had taken Tenuate Dospan and 25 had taken placebo. The two treatment groups were comparable in respect to age, height, amount overweight, and systolic and diastolic blood pressures, but mean initial weights for the two groups were not comparable (188.7 lb. for drug group and 171.6 lb. for placebo group). In order to correct for this difference, all analyses were adjusted by the initial weight of the patients.

Ten patients in the drug group and seven in the placebo group discontinued treatment before 12 weeks. Table 1 shows the average weight loss at the time of discontinuing treatment. The reasons given for dropping out of the study were: flu (one in each group), did not think treatment was successful (one in each group), out of town (one in drug group), headache (one in drug group), pregnant (one in placebo group), visits to office inconvenient (one in placebo group); reasons were not known for six in the drug group and three in the placebo group.

Table 1

average weight loss for patients discontinuing the study

duration of treatment (weeks)	diethylpropion hydrochloride		placebo	
	no. of patients	av. wt. loss (lb).	no. of patients	av. wt. loss (lb).
0- 3	3	3.8	2	3.8
4- 7	3	8.5	2	12.5
8-11	4	11.1	3	6.2

Table 2

average weight change for patients completing at least 12 weeks

treatment	no. of patients	av. duration of treatment (weeks)	weight change	
			average (lb.)	range (lb.)
diethylpropion hydrochloride	17	13.0	−17.9	−0.8 to −31.5
placebo	18	13.4	−10.7	+1.0 to −31.8

The average weight changes for the two treatment groups who completed at least 12 weeks are shown in Table 2 and cumulative loss is shown in Fig. 1. The weight loss for each group was statistically significant and the difference in weight between the two groups was significant, *i. e.* patients treated with Tenuate Dospan lost more weight than those treated with placebo ($p<.02$). All of the patients lost weight except one in the placebo group. On the average, the 17 patients treated with Tenuate Dospan lost 45.8 per cent of their initial overweight and the

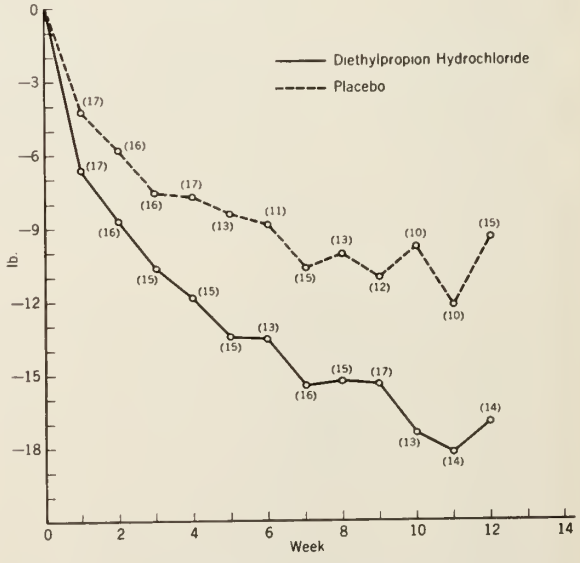


Fig. 1. Cumulative weight loss for the two treatment groups. The numbers in parentheses indicate numbers of patients.

Table 3

change in blood pressure after at least 12 weeks of treatment

medication	no. pts.	blood pressure systolic (mm. Hg.)			diastolic (mm. Hg.)		
		before	after	diff.	before	after	diff.
diethylpropion hydrochloride	16	129	124	−5	81	78	−3
placebo	17	126	128	+2	78	80	+2

18 placebo-treated patients lost 30.1 per cent.

Table 3 shows the average changes in blood pressure for the two groups. None of the changes in either systolic or diastolic pressures was significant.

At least one side effect was reported by 24 of the 27 patients treated with Tenuate Dospan and by 22 of the 25 treated with placebo. The frequency of side effects is shown in Table 4.

Table 4

frequency of side effects

side effect	frequency	
	diethylpropion hydrochloride (27 patients)	placebo (25 patients)
dry mouth	17	13
headache	17	12
nervousness	17	12
insomnia	9	9
jitteriness	8	6
nausea	7	3
dizziness	5	4
irritability	5	3
hunger	4	4
weakness	2	3
depression	2	1
cramps	1	1
constipation	0	1
ear popping	1	0
heartburn	0	1
hiccups	1	0

Discussion

It is quite evident that this study is very similar to any number of clinical investigations of obesity that are found in the medical literature. We have not attempted to prove any particular point in this investigation other than to reaffirm the problems encountered in helping patients lose weight.

We believe that it is vitally important for any one who conducts clinical investigations of anti-obesity drugs to establish a rapport with the patients that will carry through the entire study, and to instruct them carefully in what such a program entails. We also feel that an expected and predicted weight loss should be outlined at the initiation of the study and that the patients should be seen weekly. It is for this reason that in studies that we have conducted presently and in the past our control group does show a measure of success. However, in this particular study the treatment group showed a better response with the logical conclusion being that the medication was responsible for this additional weight loss.

One interesting aspect of this study was a look at the side effects, which were reported on direct questioning. When comparing the side effects encountered in the patients in the Tenuate Dospan group with the patients in the placebo group, it is interesting to note that there was no real difference in the two groups; there was an almost equal number of complaints in the placebo group and the treatment group. Therefore, it seems unlikely that side effects from the treatment versus the control group have any clinical importance in this particular study.

Summary

Fifty-two obese patients were given either Tenuate Dospan or an identical-appearing placebo in a randomized double-blind 12-week study. Since 17 patients discontinued before completing 12 weeks (ten in drug group, seven in placebo group), weight data were available for 17 patients treated with drug and 18 treated with placebo. The weight

loss for each group was significant. However, patients treated with Tenuate Dospan lost significantly more weight (average loss, —17.9 lb.) than those treated with placebo (average loss, —10.7 lb.). At least one side effect was reported by 24 of the 27 given drug and by 22 of the 25 given placebo. No significant changes were seen in either systolic or diastolic pressures.

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Calendar of Annual Meetings

Medical Association of the State of Alabama

1969, April 24-26, Carriage Inn, Huntsville

1970, April 30-May 2, Mobile

1971, April 22-24, Birmingham

1972, April 20-22, Montgomery

1973, April 18-21, Mobile

BOOKS

Of Professional Interest

THE NEGLIGENT DOCTOR, by Charles Kramer, Crown Publishers, New York, 255 pages—$5.95.

The explanatory subtitle: "Medical Malpractice in and out of Hospitals and What Can be Done About it." The author: "a prominent New York attorney who has for many years specialized in medical malpractice cases."

Of the 11 chapter headings, four are questions: Are You a Victim of Medical Negligence? Hospitals—When Are They Liable? Doomed To Die? Who Did It?

Among the others are such captions as "For Want of a Nail . . ." (a look at some malpractice cases involving anesthesia, orthopedics, and diagnostic procedures); Nobody Cared (an obstetrical case—delivery of twins, followed by death of the mother); The Mortal Sin (a urological case—a kidney operation results in injury to the ureter); The Case of the Missing Vital Signs (a surgical case—removal of the thyroid gland leads to brain damage); and The Careless Scalpel (a gynecological case— a hysterectomy with damage to the bladder and resultant urinary leakage).

Harry Sherman, M. D., Diplomate, American Board of Surgery Fellow, American College of Surgeons, writes:

"I should like to see *The Negligent Doctor* prescribed reading for all physicians. Those who maintain a serious view of their profession and its ethical requirements will enjoy it as literature, and the few who do not may profit by its object lessons."

—W. J. M., Jr.

Submaximal Exercise Testing In A Prospective Population Study Of Cerebrovascular Disease

A PRELIMINARY REPORT

*C. P. Riley, M. D.
L. T. Sheffield, M. D.
*T. D. Lampton, M. D.

Electrocardiographic submaximal exercise testing is now being incorporated into an ongoing prospective study of cerebrovascular disease in Birmingham, Alabama. This study is designed to develop and test a lay health questionnaire used as a tool for screening large population groups for stroke-proneness. The study will also supply basic data on the incidence and prevalence of cerebrovascular and cardiovascular diseases and will define and document the importance of certain risk factors related to these diseases. The incidence of positive submaximal exercise tests in a randomly selected population of this age group is not known; also unknown is the degree of risk of future coronary heart disease and stroke which a positive submaximal exercise test confers.

Methods

The total population of Birmingham was divided into seven sub-populations using 1960 census tract data. Each sub-population contains from six to 11 census tracts grouped by race, median schooling, median income, labor force (working and unemployed, male and female), median age, and population per household. Individual blocks are selected from a census tract, and everyone in a block between the ages of 50 and 69 is interviewed. In the city of Birmingham there are approximately 61,000 persons in this age group. Ten thousand subjects will be interviewed in selected blocks (randomized according to the previously mentioned factors) at a rate of 2,500 per year. Of this 10,000 a randomly selected sample of 3,000 will receive a medical examination and laboratory testing at the rate of 750 per year. Three hundred of the 3,000 also will receive re-evaluation by a neurologist; skull, abdominal, and cervical spine films; and an electroencephalogram.

Initial laboratory testing includes; serum cholesterol, triglycerides, uric acid, PBI, BUN, PCV, VDRL, blood glucose (two hours after a 75 gram carbohydrate load); urine check for protein, ketones, glucose, and occult blood; vital capacity; supraorbital thermography; PA and lateral chest X-ray; resting and submaximal exercise electrocardiograms.

Exercise testing is done on a motor driven treadmill (Quinton, model No. 18-60) using the method of Sheffield, et al[1, 2]. Subjects not receiving a digitalis preparation are tested at least one hour after a carbohydrate load. Recent or impending myocardial infarction is excluded by history, physical examination, and resting EKG. Leads are attached to the patient's hips and shoulders, and at V_5 (total of five leads) by disposable self-adhering electrodes. Recordings of V_5 are obtained as an analog signal on magnetic tape on a data acquisition cart, (Dat-EK, model No. 6509, Revision B) as described by

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Caceres, et al[15, 16]. The signal is simultaneously viewed on an oscilloscope and recorded on paper every 30 seconds during a test. After termination of exercise a recording is made on paper immediately and at 30 second intervals for six minutes. The submaximal exercise test (GXT) level is defined as that producing a heart rate of ninety per cent of the mean predicted maximal heart rate for the subject's age, as determined by Lester et al[3]. This heart rate is attained as quickly as possible and maintained for a maximum of five minutes, or until the test is terminated.

The test is terminated with the appearance of positive EKG changes, chest pain, weakness or undue fatigue, or after five minutes. Electrocardiographic responses are classified as positive if ST segment depression occurs greater than or equal to 1 mm beginning with J-point depression and continuing flat or downsloping for a duration at least equivalent to the QRS duration before beginning its return to the isoelectric line, arbitrarily defined as the PR junction. A physician and resuscitative equipment are always present during a test.

Comments

The history of exercise testing dates from 1908, when Einthoven[4] first described the effect of physical exertion on the EKG. In 1931 Wood and Wolferth[5] compared the EKG response to stair climbing of normal subjects and those with angina pectoris, and in 1933 Goldhammer and Sherf[6] recommended the exercise test for the early diagnosis of angina pectoris. Master and Jaffe[7] described the now widely used two-step test in 1941, and follow-up studies of the two-step test by Master and Rosenfeld[8], Brody[9], Mattingly[10], Robb[11], and Rumball and Acheson[12] have confirmed that EKG evidence of myocardial ischemia after exercise identifies individuals with a high degree of present or risk of future coronary heart disease. Bruce et al[17] and Doan et al[18] have reported the use of multistage maximal exercise testing, and Sheffield et al[1, 2] also use a treadmill in their submaximal (GXT) exercise testing. Long-term follow-up studies in patients who have positive responses to maximal or submaximal treadmill testing have not been reported.

Studies by Sheffield et al[1, 2] provide interesting data comparing the yield of positive responses with the GXT and the two-step exercise test. In patients with angina pectoris and no history of myocardial infarction the two-step test was positive in 65 per cent of those tested, the GXT in 79 per cent; in those with probable angina the two-step test was positive in 28 per cent, the GXT in 50 per cent; in those with angina and a history of old myocardial infarction the two-step test was positive in 38 per cent, the GXT in 54 per cent. Overall, the GXT evoked a positive response in an additional 24 per cent of patients. An additional small percentage of positive responses can be obtained by pushing the patient to maximal levels; however, patient acceptance of the 90 per cent level is greater, of obvious importance where continued patient participation is desired.

Submaximal exercise testing is safe as long as a physician is present to terminate a test and provide resuscitation, should a situation requiring such measures arise. Rarely, patients have become hypotensive or had brief runs of various tachyarrhythmias. Provocation of acute myocardial infarction by maximal stress testing is extremely rare, and death during submaximal stress testing has not been reported in this country.

An absolute statement as to whether a positive submaximal exercise test can be found in "normal" individuals cannot be made; however, Simonson[13] could not produce ischemic ST segment depression in normal young persons by the most severe exercise. J-point depression of one and one-half millimeters or less during severe exercise in this same group is very common. Although functional disorders (i. e. vasoregulatory asthenia) and some types of valvular and primary myocardial disease will occasionally

produce ST segment changes during exercise, the experience of Doan et al[14] suggests that these changes occur very rarely, if at all, in normal individuals.

A randomized population study, such as the one now underway in Birmingham, Alabama, provides an excellent opportunity to assess carefully the relative significance of various factors which may predispose to vascular diseases of all types. Of the three most commonly used electrocardiographic exercise tests, submaximal exercise testing seems to be the easiest to perform and best tolerated by the patient. Does a positive submaximal exercise test (GXT) carry the same prognosis for coronary heart disease as a positive two-step test? What is the meaning of a positive submaximal test in an asymptomatic individual? What is the risk of stroke in any individual with a positive submaximal test? What is the relationship of a positive submaximal exercise test to other cardiovascular disease risk factors? The findings of this investigation will provide some answers to these and many other questions.

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Gout and Rheumatism At The Reynolds Historical Library

Gene V. Ball, M. D.*

"A few good books, digested well, do feed the mind;

Much clogs or doth ill humors breed."

The Reynolds Historical Library is a collection of 5,000 rare books, 127 manuscripts and 29 incunabula, given by the late Lawrence Reynolds to the University of Alabama in Birmingham. Dr. Reynolds acquired important items pertaining to his specialty, radiology, and a balanced representation of works of general medical interest. This includes first editions of Harvey's *Exeratatio Anatomica de Motu Cordis et Sanguinis* and Vesalius' *Fabrica* and the *Epitome,* unpublished letters of Pasteur and Osler, a long, carefully handwritten book of notes taken by William Hunter, and letters written by both Martha and George Washington to their dentists. The collection relating to gout and rheumatism illustrates further the diversity of the library's holdings. These important volumes highlight the history of ideas pertaining to gout and rheumatism.

There are 41 'gout and rheumatism' volumes. The earliest is Ambroise Pare's *Cinq Livres de Chirurgie,* published in 1572, and one of 14 known copies. The five books of surgery comprise Bandages, Fractures, Dislocations, Bites and Poisonous Stings, and Gout. Pare, like so many physicians interested in the gout, was, himself, one of its victims. The first chapter of the Book of Gout is concerned with the derivation of the word "goutte" and of the various terms (all derived from Greek roots) localizing the gouty attack, e. g., *cheirarga* if in the hand because the Greek word for hand is cheir; *podagra* derives from pous, signifying the foot. His derivation of *siagonagra* from the word for mandible, *trachelogra* from the word for shoulder, and *rachisogra* from rachis for spine is to me an interesting indication of Pare's failure to differentiate the various types of arthritis, since gout hardly ever involves the shoulder, let alone the mandible and spine. Pare inveighed against overindulgence in alcohol and food, citing this as a cause of gout; as will be seen, this becomes the recurrent theme of later gout literature. Hermodactyl is recommended as a purgative although with no more emphasis than is given other drugs or herbs, suggesting Pare, as was true of others, did not recognize this root of *colchicum variegatum,* a close relative of *colchicum autumnale,* (the source of colchicine) as an effective drug. Nevertheless, Pare's approach was rational and he succeeded in dispelling some of the mystery attached to the disease, and his patients were not subjected to excessive bleedings.

Guillaume de Baillou, a physician to the son of Henry IV, lived from 1538 to 1616. The Reynolds Library copy of his *Opera Omnia* was published in 1762 in Geneva. This is memorable for its differentiation of gout and "rheumatism," this term having been introduced by de Baillou in its meaning of a specific form of acute arthritis. He is referred to occasionally as the father of rheu-

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matology, and as the first epidemiologist of modern times.

The remaining authors are, with few exceptions, English. The prevalence of gout seems to have been greater in England than in other countries. Cadogan blames intemperance for this high incidence of gout, noting that in England, "all degrees of men are furnished with the means of intemperance, and therefore it is no wonder that most men are intemperate. If they are less so in other countries, it is not that they have more virtue, but they want the means." These physicians brought to gout their English "logic that brings salt to soup, hammer to nail, oar to boat." They might be misinformed or overzealous but they were most often logical.

Thomas Sydenham is credited with reviving the Hippocratic method of observation and experience, this being expressed for example, in his recognition of an association between his own gout and his kidney stones. The *Entire Works* (*Omnia Opera*) and the *Tractatus de Podagra et Hydrope* are in the Reynolds Library. Perusal of these books is rewarding for the recognition of original descriptions which have become part of medical lore, e. g.,

> "Kings, great princes, generals, admirals, philosophers, and several other great men have thus lived and died. In short, it may be affirmed of this disease that it destroys more rich than poor persons and more wise men than fools."

His description of the acute gouty attack remains unsurpassed.

By the late sixteen and early seventeen hundreds, the physician authors were not content merely to describe the disease or offer a putative cure. Rather, cause and effect relationships were explored more thoroughly.

William Musgrave wrote *de Arthritide anomala, sive interna, dissertatio* in the early seventeen hundreds. Our copy was published in 1723 and has been bound with the *Opera Medica* of Sydenham. Musgrave was probably the first physician to report his observations that gout could be secondary to chronic lead intoxication, an occupational hazard of painters and plumbers. A *Treatise of the Gout,* written in 1697 by Sir John Colbatch, attests to the role of excessive blood alkali in the pathogenesis of gout, and advocates treatment with oral sulphuric acid to neutralize the alkali.

The logic which related cause and effect led to an understanding that rational treatment might be achieved by removing the cause. This proved more difficult than might be expected, since vice and intemperance in almost any form were considered to be the usual determinants of gout. Embodying this view was George Cheyne, whose *An Essay of the True Nature and due Method of Treating the Gout, Written for the use of Richard Tennyson, Esquire . . . .*, is an account of the ill effects of luxury. He noted that only temperance could cure or relieve the gout. Despite invectives against the "dissolute and voluptuous indulgence of sensual appetites of the wealthy" his medical practice was large and fashionable.

William Cadogan's similar ideas can be appreciated best by reading *A Dissertation on the Gout and all Chronic Diseases, Jointly Considered, as Proceeding From the Same Causes; What Those Causes are, and a Rational and Natural Method of Cure Proposed. Addressed to all Invalids.* As has been mentioned, this emphasizes the role of intemperance and indolence and deprecates the role of heredity in the pathogenesis of gout. The *Dissertation,* said to have had 11 editions, evoked the following from the actor, David Garrick: "Dr. C. has written a book lately upon ye gout. It is much admired and certainly has its merit—I was frightened with it for a week." The book inspired publication of at least two volumes refuting Cadogan, one of which by William Falconer was pub-

lished in 1772 under the title *Observations on Dr. Cadogan's Dissertation on the Gout and all Chronic Diseases.* This is otherwise without interest.

Reference is made to the Bible in works by Nicholas Robinson and William Stukeley, entitled respectively, *An Essay on the Gout and all Gouty Affections Incident to Affect Mankind* and *An Abstract of the Treatise of the Cause and Cure of the Gout . . .*
In his introductory discourse, a remarkable account of the history of gout, Robinson claimed Asa, King of Judah as one of its victims:

> "That King Asa, in the time of his old age, was diseased in his feet and the disease increased upon him, till it was exceedingly great or painful. As the king advanced in years, the disease became inveterate, and generated nodes and tophs in the joints of his hams, legs and feet, that rendered that prince a cripple and unable to walk."

Stukeley took as his text, "Let him dip his foot in oil. Thy shoes shall be as iron and brass; and as thy days, so shall thy strength be", and advocated treatment by external application of oils to replenish the joint oils.

William Heberden's contributions to clinical medicine are legendary. *The Commentaries on the History and Cure of Diseases* differentiate gout and rheumatism, the latter term including rheumatic fever and rheumatoid arthritis. His name is memorialized in rheumatology by its attachment to what he called simply *digitorium nodi:*

> "What are those little hard knobs, about the size of a small pea, which are frequently seen upon the fingers, particularly a little below the top, near the joint? They have no connection with the gout, being found in persons who never had it; they continue for life, and being hardly ever attended with pain, or disposed to become sores, are rather unsightly than inconvenient, though they must be some little hindrance to the free use of the fingers."

The Practice of Physic, authored in 1793 by William Cullen, the Professor of Physic at Edinburgh, was in use as a standard text for 100 years. This book accompanied the 49'ers to California; one can surmise the prospectors must have scorned remedies which demanded, as they did, abstinence from animal food and all fermented or spiritous liquors. In *The Practice of Physic* and *Nosology,* published in 1800, he classified diseases into fevers, neuroses, cachexias, and local disorders. Gout was listed as podagra under class pyrexia, order phlegmasia; the most appropriate definition of the latter being "inflammatory fever in a particular external place." Can Cullen's one sentence description of articular gout be improved upon?

> "Podagra regularis, with pretty violent inflammation of the joints, enduring for several days, and receding gradually with swelling, itching, and desquamation of the part affected."

Cullen observed, under chronic rheumatism, a rigidity of the muscles causing restricted and painful motion. The concept of fibromyositis complicating rheumatoid arthritis is timely and still debated by rheumatologists.

A noteworthy feature of Samuel Cooper's *A Treatise on the Diseases of the Joints,* which won the prize given by the Royal College of Surgeons in 1806, is the discussion of scrofulous joints. One can read this as a good clinical description of tuberculous arthritis.

In 1818 the London Directory (Year Book) estimated the incidence of gout as one in 26 among the upper classes in London, whereas its rarity in Glasgow was confirmed by Charles Scudamore in *A Treatise on the Nature and Cure of Gout.* He attributed this to differences in habits between the residents of the two cities. Everyone in Glasgow walked, there being only 20 private carriages in the city, and punch, rather than wine, was the favored drink. The statistical tabulations of the age of onset of gout, and the height and body build of its sufferers, mark Scudamore

as one of the earliest of modern epidemiologists.

There are doubtless many reasons why gout has been a favored disease among writers. Gardiner, for example, said that among the chronic diseases which afflict mankind, none deserves more a serious investigation than gout. Until the late 1800's any disease with associated arthritis might have been called gout, and diagnostic parsimony and simplicity compelled the recognition of visceral complications of gout. Thus, a more or less direct imagined connection between gouty arthritis and the stomach gave rise to a system in which 'atonic' gout was thought of as atony of the stomach or other internal part without inflammation in the joints or with only slight or transient pains in the joints. 'Retrocedent' gout was "with inflammation of the joints suddenly receding, and quickly followed by atony of the stomach or some other internal part." 'Misplaced gout' differed from atony in its insistence on the inflammatory nature of the internal effect. Attachment to the idea of internal involvement persisted; in 1846 Chapman explained the difference between gout and rheumatism by noting that gout always originated internally and rheumatism very seldom.

An interesting example of mistaken diagnosis is Scudamore's description of the premonitory symptoms of gout. This description may be the earliest, although incomplete, account of Reiter's disease or gonococcal arthritis: "heat of the eyes, with slight membranous inflammation; or a remarkable irritability of the bladder and urethra, with increased secretion in the mucus membrane of these parts, prevails in some persons shortly before the fit; and in those whose urethra is affected with stricture, these symptoms almost certainly take place." Scudamore quotes Sir Everard Home: "So much is the urethra in its natural state under the influence of gout, that it is sometimes affected by it on the coming on of every attack, with all the symptoms of inflammation, as pain in making water, and a purulent discharge, and as soon as the gout fixes itself in the foot, they entirely disappear."

Only 15 years separate Chapman's *Lectures* with their stress on visceral gout, and the publication of Alfred Baring Garrod's *The Nature and Treatment of Gout and Rheumatic Gout,* yet it might have been 100 years, so different are they, and so well does Garrod represent the contemporary concept of the scientist in medicine. Garrod's book is undoubtedly a scientific *tour de force,* and perhaps one of the most important books written by a physician. Though Garrod was not the first to analyze tophi correctly as uric acid, he was the first to affirm its deposition, always in a crystalline form, as urate of soda. By analyzing the blood of more than 100 patients, whose gout has been described carefully, leaving little doubt of the correctness of his diagnosis, he proved for the first time that a compound present in the blood normally in small amounts could in larger amounts be responsible for a specific disease. The illustrations of the appearance of the crystals viewed in polarizing light are among many excellent illustrations of involved hands and feet, kidneys, etc. Garrod furthermore illustrated the crystalline urate of soda obtained from gouty joints, an observation only recently revitalized. There is no really significant work in the Reynolds collection illustrating the history of gout as it has evolved after Garrod. This history is still being written.

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. . . Opera omnia in quatuor tomos divisa, studio et opera. M. Jacobi Thevart, medici parisiensis, digesta, denuo in lucem edita: cum praefatione Theodori Tronchin, . . . Genevae, apud fratres de Tournes. M.DCC.LXII.

4 vols. in 2.

Baillou is generally considered the father of rheumatism. He first clearly drew the distinction clinically between gout and rheumatism. (Copeman, Short Hist. Gout, p. 2, 120)

Cadogan, William, 1711-1797.

A dissertation on the gout, and all chronic diseases, jointly considered, as proceeding from the

fame causes; what thofe causes are; and a rational and natural method of cure propofed. Addreffed to all invalids. By William Cadogan, fellow of the College of Physicians. Philadelphia: printed for and sold by R. Aitken, at his book-store nearly oppofite the London-Coffee-houfe, in Front-ftreet. 1772

iv, 39 p.

Cheyne, George, 1671-1743.

An essay of the true nature and due method of treating the gout, written for the ufe of Richard Tennison, Efq; together with an account of the nature and quality of bath-waters, the manner of ufing them, and the difeafes in which they are proper; as also, of the nature and cure of moft chronical diftempers; not publifh'd before. By Geo. Cheyne, M. D. & F. R. S. The seventh edition, revis'd, corrected and enlarg'd to more than double the former. London: printed for G. Strahan, at the Golden Ball, over againft the Royal Exchange in Cornhill, and sold by W. Mears, without Temple-Bar, and J. Leak, at the Bath. M.DCC.XXV.

iv, 5C, 133 p.

Presentation inscriptions on end paper, Dr. Kidner from Dr. John B. Hawes, 1937; Dr. Reynolds from Dr. Clinton Kidner, 1946.

Falconer, William, 1744-1824.

Observations on Dr. Cadogan's Dissertation on the gout and all chronic diseases. By William Falconer, of Bath, M. D. Edition, the third, with several corrections and additions, not before printed. Bath: printed by R. Cruttwell, and sold by J. Dodsley, Pall-Mall; F. Newberry, Corner of St. Paul's Church-Yard; and T. Lowndes, Fleet-Street, London; also by A. Tennent, and W. Bally, in Milsom-Street, Bath. MDCCLXXII.

vi, 7-104 p.

Garrod, Sir Alfred Baring, 1819-1907.

The nature and treatment of gout and rheumatic gout, by Alfred Baring Garrod. London, Walton and Maberly, 1859.

xvi, 601, 8 (advertisements) p.

Garrod, Sir Archibald Edward, 1857-1936.

A treatise on rheumatism and rheumatoid arthritis, by Archibald E. Garrod. London, Charles Griffin, 1890.

xii, 342, 31 p. diagrs. (fold.)

Kinglake, Robert, 1765-1842.

A dissertation on gout; exhibiting a new view of the origin, nature, cause, cure, and prevention, of that afflicting disease; illustrated and confirmed by a variety of original and communicated cases. By Robert Kinglake, M. D. London; printed for John Murray. 1804.

xx, 348, 10 p.

Pare, Ambroise, 1510?-1590.

Cinq livres de chirurgie. 1. Des bandages. 2. Des fractures. 3. Des luxations, auec vne apologie touchant les harquebousades. 4. Des morsures & piqueures venimeuses. 5. Des gouttes. . . . A Paris, chez Andre' Wechel. Auec priuilege du roy. 1572.

24, 470, 22 p. port., illus.

Woodcut portrait of Pare, age 55, with his motto. Illustrations include 8 woodcuts of chemical apparatus. Manuscript notes on end paper.

There are 14 known copies. This work has been called Pare's masterpiece. It is the first appearance of the whole teaching of bandages, fractures and dislocations which has come down to us from the ancients, broadened by Pare's own experience. (Doe)

Robinson, Nicholas.

An essay on the gout, and all gouty affections incident to affect mankind . . . by Nicholas Robinson . . . London: printed for Edward Robinson. n. d.

xii, 178 p.

Scudamore, Sir Charles, 1779-1849.

A treatise on the nature and cure of gout, comprehending a general view of a morbid state of the digestive organs; and of regimen; with some observations on rheumatism. By Charles Scudamore. London: printed for the author, and sold by Longman, Hurst, Rees, Orme, and Brown, Paternoster Row. 1816.

xix, 402 p.

Scudamore, Sir Charles, 1779-1849.

A treatise on the nature and cure of gout and rheumatism, including general consideration on morbid states of the digestive organs; some remarks on regimen; and practical observations on gravel. By Charles Scudamore . . . 1st American, from the 2d London ed. Philadelphia: published by Edward Earle, corner of Fourth and Library streets. William Brown, printer. 1819.

xix, 335 p.

Sydenham, Thomas, 1624-1689.

Tractatus de podagra et hydrope. Per Tho Sydenham, M. D. Londini, typis R. N. impensis Gualt. Kettilby ad insigne Capitis Episcopi in coemeterio Paulino. MDCLXXXIII.

10, 201, 1, p.

First edition.

Signatures in ink on end paper, Roberti Bridges, dated 1876. Marginal notes in ink.

Dedicated to Dr. Thomas Short.

Of his many works, Sydenham's treatise on gout is considered his masterwork. He clearly differentiated gout from rheumatism. (Garrison-Morton)

Additional references can be obtained upon request.

Mental Health And The University Student

Kenneth Rockwell, M. D.

University, Alabama

A fair question is: Do people of college age have any mental health problems serious and frequent enough to require professional services? I think the answer is: If people of other ages do, yes, so do college students. To give the most serious example, suicide is the third leading cause of death in the 18 to 30 age group in the United States today. Most suicides are thought to result from emotional distress.

One purpose of this paper is to present two topics related to student mental health and counseling with a view to conveying an idea about some of the concepts with which people engaged in student mental health work and some of the problems they work on. A second purpose is to present an outline of the counseling resources available at present at the University of Alabama.

First let us take up the normal developmental tasks facing every college student, six of which seem to be outstanding at this particular time and situation in life, and these are:

1) Changing from relations of dependence upon one's parents and other older people to those of independence;

2) Dealing with authority;

3) Learning to deal with uncertainty and ambiguity, particularly in matters involving the balance between love and hatred;

4) Developing a mature sexuality;

5) Finding security, developing feelings of adequacy or competence, and attaining prestige or esteem;

6) Development of standards and value systems.

The first of these, developing independence, is the major problem, and a lack of independence seems to be a significant part of the problem of almost every troubled student I see. College students in general do face in two directions at once like Janus—toward their families and toward the world beyond college. Timewise, that is backward and forward, respectively. Disturbed students that I consult with seem to be facing mostly backwards. One of the chief difficulties in that posture is that they have not yet decided who is going to do the deciding. Now that may sound like gobbledygook, but when it comes to decision making their problem seems to be not so much an inability to consider intelligently alternatives and possibilities, it seems to be a lack of the feeling that the decision is theirs to make.

Achieving independence is intricate, and I will only say a couple of other things about it. Most college freshmen probably haven't decided that they are going to do the deciding. They only look as if they have, if that. Most college seniors should have taken over the reins and be grappling with decisions on their own terms. There is a lot of mileage in between, the major part of which is in assuming responsibility for themselves.

Dealing with authority.

The problem of the college student here lies in the shift from personal to impersonal authority figures. (Some of this may have

Note: The sections of this paper on "developmental tasks" and "major problems" draw heavily on Dr. Dana L. Farnsworth's Psychiatry, Education, and the Young Adult (Springfield, Illinois: Charles C. Thomas, 1966), and his book is highly recommended for a comprehensive overview of current college mental health issues.

come up in a boarding school.) The adolescent is by nature headed toward self direction. I think he often says to himself: "When I get out from under my parents I am going to do just as I please." Well, now, that's a hell of a pleasant delusion, and it's known as license, not liberty. But it may seem possible in a college setting at first blush, because there is probably more freedom from restraint and responsibility than ever before or again. Expressions of authority usually come from people not close personally to the student and it takes some intellectual doings on the student's part to understand that someone who does not know him personally can actually put controls on him.

The emotional response to impersonal authority almost always mirrors the response learned from experience with parents, and as such will show if parents have acted consistently, reasonably, and in response to the child's needs as well as their own.

Learning to deal with uncertainty and ambiguity, particularly in matters involving the balance between love and hate.

On the social level the college student of today is faced with more career choices than before, any one of many of which would probably be personally satisfying. The differences in careers may be rather subtle, and therefore confusing. There are more choices that are acceptable from the standpoint of his expected social status, too. For the women the choice of career or family or both is often perplexing.

On the level of personal relationships, however, I think the problem of ambiguity, of the balance between love and hate, is much the same as always. The individual needs to learn to accept within himself feelings that are less than 100 per cent all the time, that is, both positive and negative feelings, in shades of gray, and sometimes simultaneously to boot. Otherwise, marriage may be quite a strain, for example. There was a gentleman who was asked on the occasion of his 50th wedding anniversary if he had ever thought of divorce. After a startled instant he replied: "Divorce? no; murder, yes."

Developing a mature sexuality.

Like electricity, mature sexuality is hard to define, but everybody needs it. All is confusion when it comes to sex. It is little taught in schools. Law, as an institution, has relatively little to say and that likely to be more moralistic than rational in background. Organized religion lags and doesn't deal with the germane issues. Communications media and commercial interests add to the confusion by representing stimulation as sexuality.

I have two things to say here: a) Sex and sexuality are by and large personal matters only, and they have been made far too public; b) If the young adult is not simply overwhelmed by the confusion, sex is an excellent area which he can actually develop in his own way and have the pride of accomplishment against heavy odds.

This is not to say that we should quit trying to figure out better ways of presenting sexuality to the young.

Finding security, developing feelings of adequacy or competence, and attaining prestige or esteem.

Security, prestige, and feelings of adequacy, are positive elements hopefully provided in the home and its environs for the child. The developmental task is one of learning how to create them for oneself. The key is in developing competence. Ideally competence needs to be achieved in many areas, particularly social and vocational (or prevocational in college). I think we tend to become too complex, though, and expect too many competencies, and I think it is worth mentioning that a sense of competency in *only one* area is infinitely better than no feeling of competency at all. It is hard enough to be good at one thing, after all. Concretely, sometimes a B on a report card is more important than an F.

Development of Standards and Value Systems.

There is no such thing as a human being without standards and a system of values and the battle between the generations about values is one of the biggest bug-bears today. Perhaps it was ever thus.

Some parents have about taken the position that since their children attack any and all values the parents express it is better to express none, or even have none! Inconceivable. The having of values is a model in itself and one that children and adolescents can't do without. The task in college is to make standards and values part of oneself, not just something superimposed. The majority of values so taken in are really similar to those of the parents, anyway; but values are dear, and deviations in the child are painful for the parent, so the battle rages on.

There are two other things worth saying here, though. First, regardless of the standards eventually adopted by the adolescent, the best parental model he can have is one in which standards and behavior have coincided: and secondly, parents should continue to struggle, as best they know how, to instill the best standards they can in their children, since, things being as they are, there will be from elsewhere plenty of influence in a negative direction. The children may not adopt completely the parental standards, but they will appreciate the struggle.

For the second topic let us look at four major problem areas, to wit: suicide, dropouts, drugs, and sexual morality.

Suicide.

Suicide is the most feared consequence of emotional disturbance, and rightly so. There have been public statements to the effect that suicide among college students is increasing, but there are no comprehensive statistics to show this. What I think has happened is that more people know about the suicides that do occur. It is estimated that there is an average of about one suicide per year for every 10,000 college students. The figure for students is half again as much as for non-collegians of the same age, by the way. For every suicide there may be as many as ten attempts, it is thought.

Young people, probably more frequently than older ones, make suicide attempts impulsively as a result of the distress of the moment. Some of their attempts are not well planned, but this also means that a half-hearted attempt can misfire and succeed. I interviewed a college junior who had waded out into the Potomac River with suicide on his mind. When he began to be sucked into the ooze he panicked and after a desperate struggle regained dry land minus his shoes. He had almost succeeded in spite of himself.

In trying to cope with suicidal people of any age, most of whom are depressed, two things seem to stand out.

1. Anyone who talks either directly or indirectly of self destruction must be taken seriously—"barking dogs do bite."

2. If a person is suspected of having self-destructive tendencies, some one or some ones must make every effort to maintain an open line of warm personal communication with the distressed person.

Dropouts.

The dropout problem has also received much publicity, but there is no evidence to show that the dropout rate is increasing. It has always been high in secondary schools and colleges. From 1913 to 1962 studies concerned with dropouts have shown that consistently about 60 per cent of students failed to graduate from the college they entered. Some of these graduated elsewhere, but the net loss to higher education—permanent dropout, if you will—has probably been between 40 and 50 per cent of those who started.

Over the years the reasons for dropout have changed, though. Academic ability has become less and less a factor, so that in some schools, anyway, there seems to be no difference in the intellectual capacity of those who drop out and those who don't. Factors related to withdrawal from college now are motiva-

tion, adjustment, illness or injury, and finances. It is meaningless to define as a drop-out anyone who doesn't finish his school of entrance in four years. In spite of the clamor that everyone should go to college there are those whose aptitudes, interests, personal characteristics, and career objectives are not compatible with the college experience. Others may be suited for college but not necessarily four straight years of it, or for the college they entered. Among these are students who are indecisive about career goals and need more time to make up their minds. Many such students have benefitted by a year of independent existence—that is, living away from home while working at a regular job. (The draft situation has really interfered here). This is not to deny that more often than not withdrawal from school means trouble.

Drugs.

I get the feeling that the aura surrounding the topic of drugs today is the same as was the aura surrounding alcohol during prohibition. Drug abuse will not disappear if we ignore it, but our own excitement and irrationality in discussing it and handling it serve to make it more inviting to the experiment minded adolescent. Adding 200 men to a pitifully small national narcotics force is like supercharging the air rifle you are hunting a rhinoceros with.

There are scientific studies which show that excessive use of any drug is bad for you, be it tobacco, alcohol, marijuana, pep pills, barbiturates, opium, or LSD. Also some of these drugs are in fact more dangerous than others.

There is evidence to show that use and abuse of the more powerful and dangerous drugs has been on the increase on many college campuses for at least the past five years, and the trend is probably still upward.

It can also be said that those frequent drug users who have come to the attention of psychiatrists have been found almost always to be people who were at least moderately psychologically disturbed prior to drug use and whose disturbance was almost never diminished by the drug, but rather was either unaffected, increased, or complicated by it. It is tempting but risky to suggest the same findings for those who do not come to public attention.

However, at this hysterical stage of the issue, young people will pay little attention to the most dispassionate presentation of solid scientific findings; and to preach the evils of drugs to them—which is what is being done mostly—is to invite rebellion via drug abuse. In my opinion, even policy statements by university administrations are likely to invoke rebellion, and such statements, if they must be made, should probably be limited to something on the order of: "We will handle each instance on its own merits and in accordance with local law."

Sexual Morality.

There is a general impression backed by some, but not conclusive evidence, that sexual activity is on the increase among young unmarried people and that earlier ages are also involved. This is against traditional morality which urges restraint. If the general impression is correct, it remains to be seen whether or not increased sexual activity will undermine the institution of marriage or otherwise weaken the moral fibre of society. Actually, there seems to be developing a new morality in which the quality of the love relationship is paramount and love and consideration are supposed to precede physical sex.

What seems to be most important is that there be a definite sexual morality and clear standards of behavior. When it comes to deciding just what these should be, communication within and between generations is hampered by many factors, among them: lack of consensus as to what the central issues are, criticism of those who become interested in the subject, and lack of competent people to hold discussion groups.

What resources for personal counseling with students are currently available at the

University of Alabama at Tuscaloosa? There are at least eight.

First, some faculty members become interested in students personally. Such interest is usually not generated by a student's personal "problem" and "counseling" need never enter the picture as such, but "problems" and "counseling" are likely to come out indirectly and many quandaries dealt with before complications set in. In my opinion it is essential that there be informal contact between faculty members and at least some students ("some," so that all will know it is available), at the individual and personal level. Without such contact the university will remain impersonal and students will not feel that they are a part of it. Freshmen, especially, want to feel that someone in the University is interested in them.

Deans and their staffs, and house directors and dormitory counselors comprise two other resources. All of these people have administrative and other duties, but as they come into close contact with students, their administrative function may recede, and a lot of needed counseling takes place, whether it is called that or not.

Ministers in the community are a traditional source of personal counseling. The fact that several of them are directly affiliated with the University makes them more available to the students and focuses their attention on special student problems.

There are four University Departments on the staffs of which are specialists who deal with one sort or other of personal problem and all of whom do personal counseling. These are: The Speech and Hearing Center, the Education Department with its Counseling and Guidance section, the Psychological Clinic, and the Student Health Service. The four Departments function independently, and all offer services to students. Educationalists, psychiatrists, psychologists, and social workers are available on one or more staffs and are participating in counseling programs which are established in fact. The current orientation of these programs is toward more contact with students and campus mental health issues, a posture in keeping with the facts of a steadily expanding student body and the generally increasing delineation of the college population as a distinctive subgroup.

Present indications are that there is movement in the direction of increased communications among the various counseling resources, and that the resources are becoming more generally known and used—in short, expansion.

The Student Health Service proper now has a mental health section consisting of a full time psychiatrist and a three-fifths time psychologist. (The full time psychiatrist is "made up of" Drs. Inez Fowler, Lewis Sharman, and Kenneth Rockwell; the psychologist is Dr. Donald Schrag.) Our major activity is direct service to the students: individual brief psychotherapy (average of about five visits) in which the emphasis is on current function. (Students are entitled to this treatment when they pay their Health Service fee.)

A second activity, important if less time occupying, is developing and maintaining communications both inside and outside the University. For example, we are having with some of the dorm counselors regular discussions about how to handle problems, which kinds need a mental health referral, and how to make the referral. Other than treatment, though, what we are doing most frequently is consultation with someone who is concerned about the behavior of a particular student. Anyone may have such consultation, the only limitation being that a student or prospective student be the subject.

The foregoing presentation has been intended as a sampler of college mental health issues in general and counseling resources at the University of Alabama in particular. College health, both physical and mental, is relatively new as a distinct, growing field. The workers tend to be enthusiastic and the issues lively; therefore the flavors in the sampler are subject to change without notice.

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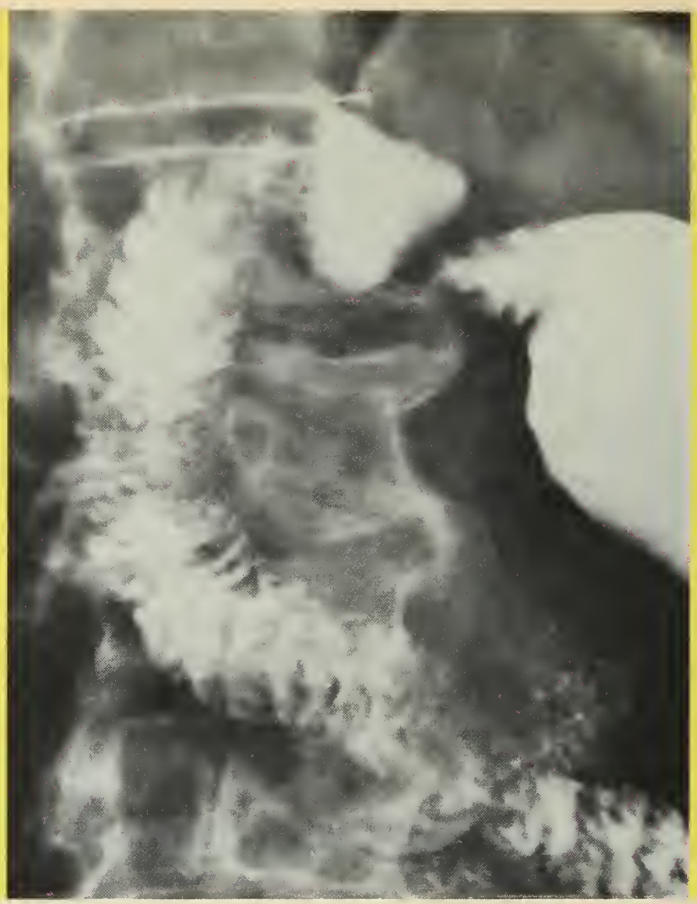
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(1) Bilbao, M. K.; Frische, L. H.; Rösch, J., and Dotter, C. T.: Hypotonic Duodenography, Scientific Exhibit, Radiological Society of North America, Chicago, Nov. 27–Dec. 2, 1966.

(2) Bilbao, M. K.; Frische, L. H.; Dotter, C. T., and Rösch, J.: Hypotonic Duodenography, Radiology *89*:438-443 (Sept.) 1967.

See also: Liotta, D.: Pour le diagnostic des tumeurs du pancréas: La duodénographie hypotonique, Lyon chir. 50:445-460 (May-June) 1955.

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Alcoholism And Drug Dependence

In this restless climate of incessant and rapid national change, social turmoil, uncertainty of the future and erosion of family communications, two severe but elusive medical problems—rising alcoholism and drug abuse—have emerged into sharp focus.

Since there are at least four million alcoholics in the nation (some estimates of liberal definition go as high as nine) and an unknown, but growing number of statistically uncountable individuals dependent on other drugs, the havoc they are wreaking upon themselves, their families and society in general is immense. Alcoholism, without question, is one of the top health problems in the U. S.

From a medical standpoint the severity of the closely related problems of alcoholism and drug dependence is further compounded because relatively few medical schools include much about alcoholism in their curriculums, few interns and residents have the opportunity to observe or treat alcoholics since many hospitals refuse to admit alcoholics, conflicting medical opinions exist about some drugs of abuse and the strengths and components of clandestine drugs are unknown.

Having little or no exposure or experience in these areas of medical concern, it has been initially difficult for many physicians to know where or how to begin in their treatment of such patients. Introduction of "fad" drugs like LSD and Speed and the sparsity of definitive scientific information about them, marihuana and some other drugs have further complicated the situation.

And if many physicians have, at times, been in a quandary, think of what it's been like for concerned parents, health educators and other lay people who have been bombarded by the press with often diametrically opposing views about current drugs of abuse.

Concerned with the growing magnitude of alcoholism and other drug abuse problems, the AMA's Committee on Alcoholism and Drug Dependence, a committee of the Council on Mental Health, has been accelerating its activities almost since its inception in 1963 in the hope of stemming the tide.

Recognizing the urgent need for large-scale educational programs aimed at both the profession and the public, the committee, comprised of eight physicians having a high degree of competence in various disciplines relating to the problems at hand, has carried out or assisted in extensive projects, often in cooperation and liaison with other organizations and with individual expert consultants. The AMA has earned plaudits from both within and without the profession for its positive approach to the problems and its efforts to solve them.

In an attempt to clarify the previously somewhat muddled situation on marihuana, the Council on Mental Health and the committee joined with the Committee on Problems of Drug Dependence of the National Research Council, National Academy of Sciences, in presenting an indicting statement, "Marihuana and Society," published in the June 24 issue of the *Journal of the American Medical Association,* and also reported at the AMA's 117th Annual Convention held in San Francisco in June.

From its beginning, the committee has undertaken the preparation of succinct statements aimed at informing the practicing physician of the latest developments in drug problems, of major considerations in diagnosis and treatment of drug dependence and also of approaches to rehabilitating drug dependent patients to normal life.

Such statements, appearing as articles in the *Journal of the American Medical Association,* have included: "Narcotics and Medical Practice," "Dependence on Barbiturates and Other Sedative Drugs," "Dependence on Am-

phetamines and Other Stimulant Drugs," "Dependence on Cannabis (Marihuana)," "Management of Narcotic-Drug Dependence by High-Dosage Methadone HCL Technique," "Dependence on LSD and Other Hallucogenic Drugs," and "Marihuana and Society."

For the enlightenment of the public and in response to repeated inquiries from alarmed or confused parents, the committee last year introduced "The Crutch That Cripples: Drug Dependence," a comprehensive, easy-to-read booklet now in its second printing.

It also has introduced two significant new publications dealing with alcoholism—*The Manual on Alcoholism*, a 100-page physician guide outlining major factors in the causes, diagnosis and treatment of alcoholism and medical management of alcoholic patients, and "The Illness Called Alcoholism," a 16-page pamphlet written to educate the laity.

Through the committee's 10-point program on alcoholism, state medical societies are working with appropriate officials to expand present inadequate treatment facilities for alcoholic patients and to convince hospitals that they should admit alcoholics as patients.

As a step in its educational program for physicians, the committee developed a new exhibit, "The Drug Dependent Patient," which describes the four categories of dependency-inducing drugs. It now is formulating plans for an exhibit on treating alcoholism.

The committee, staffed by the Department of Mental Health, represents a merger of two previous committees—one on alcoholism, formed in 1954, and the other on narcotics addiction, established in 1955. In addition to carrying out assignments suggested by the Council on Mental Health, it also initiates projects on its own.



AMA Guidelines On Transplants

Ethical guidelines concerning organ transplants, submitted by the AMA's Judicial Council, were approved by the House of Delegates at the 1968 Annual Convention in San Francisco.

According to the Judicial Council's opinion, "A man in the final analysis, must make a decision whether to permit or to perform a transplantation procedure. The decision must be a reasoned, intellectual decision, not an emotional decision. As medical science advances, and as technological skill increases, the ethical questions involved may become increasingly complex and difficult."

The Council offers the following statements for the guidance of physicians as they seek to maintain the highest level of ethical conduct in their practice.

* Since the physician's primary concern is the health of his patient, care must be taken to protect the rights of both the donor and the recipient, and no physician may assume the responsibility in organ transplantation unless the rights of both donor and recipient are equally protected.

* A prospective organ transplant offers no justification for relaxation of the usual standards of medical care. Hence, the physician should provide a prospective organ donor with the same care usually given others being treated for similar injury or disease.

* When a vital, single organ is to be transplanted, the death of the donor shall have been determined by at least one physician other than the recipient's physician. Death shall be determined by the clinical judgment of the physician, using all available, currently accepted scientific tests.

* There should be full discussion of the proposed procedure with the donor and the recipient or their responsible relatives or representatives. The physician's interest in advancing scientific knowledge must always be secondary to his primary concern for the patient.

* Transplantations should be undertaken only by physicians who possess special medical knowledge and technical competence and in medical institutions with facilities adequate to protect the health and well-being of the parties to the procedure.

* Transplants should be undertaken only after careful evaluation of the availability and effectiveness of other possible therapy.

* Discreet public reports to the communications media may be made by a properly authorized physician but should be followed as soon as possible by full scientific reports to the profession.

The Judicial Council adds that reporting of medical surgical procedures should always be objective and factual. In turn, such reporting will enhance the stature of the medical profession and its service to mankind.

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Left to right: "Are You Communicating?" Subject of H. Lindy Martin, Director, Auxiliary Services, Samford University. Dr. Robert B. Adams, Montgomery, Sunday morning speaker. Trio of leaders: Barbara Tubb, AMAA president; Jackie Carrol, Seminar chairman; Margaret Swank, Newark, Ohio, AAMA president.







Left to right: MASA President Dr. E. L. McCafferty, Jr., and Mrs. McCafferty. Nina Miglionico, Birmingham City Council, seminar speaker. Dr. William L. Smith, Editor-in-chief, MASA's Journal.



A paper discussed: Barbara Tubb, Kathryn Mostellar of Wedowee, Margaret Swank, Dura Benefield, also Wedowee.



At registration desk: Duann Cross, Mona Seabury, both Montgomery.



Dr. T. C. Nolan, at microphone; Bill Morrison with lifelike dummy, Resusci-Ann.



Decatur quintet at coffee break: Audra Stonebridge, Ruby Greenhaw, Frances Dutton, Rubye Hill, Lucille Melonas.



Two of Many; Dorothy Norris, Andalusia, and Ruth Bodden, Mobile.



An interlude for four: Marion Ziegelmeier, Mobile; Jeannie Waugh, Birmingham; Ruth K. Bodden, Mobile; Mildred White, Huntsville.



Coffee—with a cotton-pickin' background: Pamela Ridgeway and Hilda Cummings, Daphne.



Luncheon interlude: Barbara Tubb, Margaret Swank, Marjorie Peavy.

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Martin Cowan, M. D., University of Buffalo School of Medicine, 1962, Reciprocity with National Board of Medical Examiners—Intends to locate at Fort Rucker.



Hugh Chester Boston, Jr., M. D., Medical College of Alabama, 1967, Reciprocity with National Board of Medical Examiners—Intends to locate in Arab or Florence.



Larry Jan Davis, M. D., Medical College of Alabama, 1967, Reciprocity with National Board of Medical Examiners—Intends to locate in North Alabama.



Floyd Thomas Boudreau, III, M. D., Medical College of Alabama, 1967, Reciprocity with National Board of Medical Examiners—Intends to locate in Mobile.



James William DeRuiter, M. D., University of Mississippi School of Medicine, 1960, Reciprocity with Mississippi—Intends to locate in Talladega.

(Continued on Page 241)

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Precautions: Use may result in overgrowth of nonsusceptible organisms. Constant observation is essential. If new infections appear, take appropriate measures. Use of tetracycline during teeth development may cause discoloration of teeth.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes (a case of exfoliative dermatitis has been reported); photosensitivity reaction, onycholysis and discoloration of nails (rare). Kidney—rise in BUN, apparently dose-related. Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. In young infants, bulging fontanels have been reported following full therapeutic dosage. This symptom has disappeared rapidly when drug is discontinued. Teeth—dental staining (yellow-brown) in children of mothers given tetracycline during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. Blood—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. Liver—cholestasis (rare), usually at high dosage. Tetracycline may form a stable calcium complex in bone-forming tissue. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy.

Average Adult Daily Dosage: One Gm. per day, in 4 divided doses of 250 mg. each. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

ACHROMYCIN® WORKS HERE
TETRACYCLINE

Actually ACHROMYCIN works wherever the infection is due to an organism your lab cultures have shown to be tetracycline-sensitive. No other tetracycline—or analogue—can assure you of quicker or more effective antibiotic action. After all, isn't that what you want for your patient?

ACHROMYCIN was a pioneer in tetracycline therapy. Seventeen years of experience have shown that when the respiratory system, the genitourinary system, or the skin and soft tissue require treatment for infection probably caused by any of a number of sensitive strains, ACHROMYCIN is a wise choice for therapy while awaiting test results.

Available in 31 useful forms to meet your situational needs.

ACHROMYCIN® V
TETRACYCLINE CAPSULES

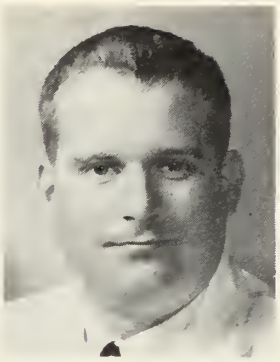
The cost differential—inconsequential

Lederle
LEDERLE LABORATORIES
A Division of
American Cyanamid Company
Pearl River, New York 10965

(Continued from Page 236)



Thomas Ashford Gibson, M. D., Emory University School of Medicine, 1955, Reciprocity with Georgia—Intends to locate in Scottsboro.

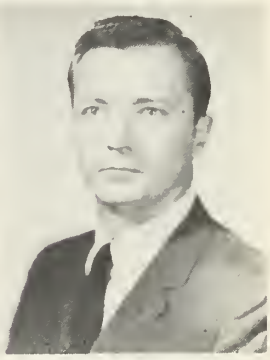


Jack Lindsey Magness, Jr., M. D., University of Arkansas School of Medicine, 1965, Reciprocity with Arkansas—Intends to locate in Montgomery (Maxwell).



Richard William Hehn, M. D., University of Oregon Medical School, 1963, Reciprocity with Oregon—Intends to locate in Birmingham.

Douglas Samuel McCall, M. D., Jefferson Medical College, 1962, Reciprocity with Pennsylvania—Intends to locate in Birmingham.





Gerald Martin Hollingsworth, M. D., Harvard Medical School, 1955, Reciprocity with Mississippi—Intends to locate in Graysville.

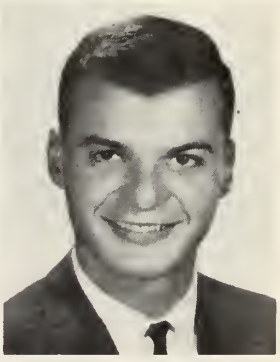


Hamlet Tatum Newsom, M. D., Medical College of Alabama, 1967, Reciprocity with National Board of Medical Examiners—Intends to locate in Montgomery.



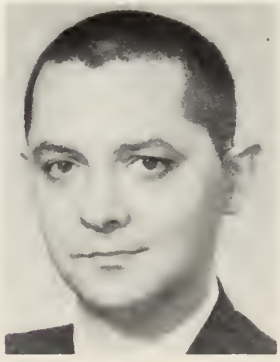
Antoinette Foote Hood, M. D., Vanderbilt University School of Medicine, 1967, Reciprocity with National Board of Medical Examiners—Intends to locate in Scottsboro.

Albert Dominick Pacifico, M. D., Seton Hall College of Medicine (Now New Jersey), 1964, Reciprocity with National Board of Medical Examiners—Intends to locate in Birmingham.

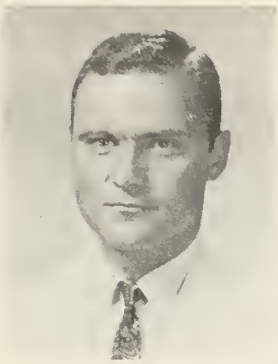




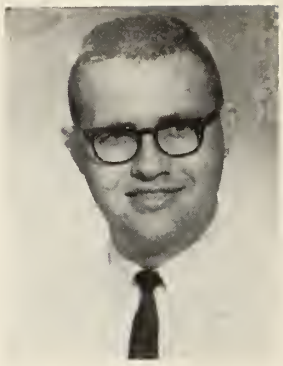
Charles Edward Hood, M. D., Vanderbilt University School of Medicine, 1967, Reciprocity with National Board of Medical Examiners—Intends to locate in Scottsboro.



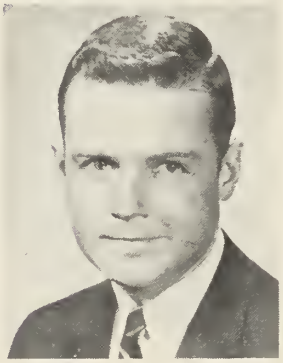
James Whyteman Richardson, M. D., Emory University School of Medicine, 1965, Reciprocity with Georgia—Intends to locate in Huntsville.



Robert Burke Russell, M. D., Louisiana State University School of Medicine, 1967, Reciprocity with Louisiana—Intends to locate at Spanish Fort.



William Pearson Clack, M. D., Medical College of Alabama, 1967, Reciprocity with National Board of Medical Examiners—Intends to locate in Lipscomb.



Don Allan Wheeler, M. D., University of Tennessee College of Medicine, 1961, Reciprocity with Tennessee—Intends to locate in Huntsville.

James Robert Collier, M. D., Medical College of Georgia, 1949, Reciprocity with Georgia—Intends to locate in Gadsden.





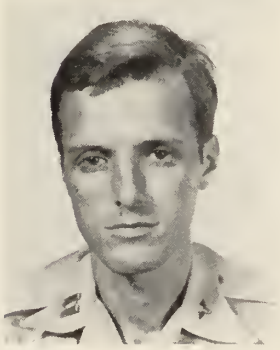
William Clinton White, M. D., University of Virginia School of Medicine, 1937, Reciprocity with Virginia—Intends to locate in South Baldwin County.



Louie Cecil Wilson, M. D., Tulane University School of Medicine, 1963, Reciprocity with Louisiana—Intends to locate in Mobile.



William Curtis Williston, M. D., Western Reserve University School of Medicine, 1967, Reciprocity with National Board of Medical Examiners—Intends to locate in Birmingham.



John Howard Gundy, M. D,. Cornell University School of Medicine, 1962, Reciprocity with National Board of Medical Examiners—Intends to locate in Anniston.

To fight TB- find it first!

Make tuberculin testing routine with every physical examination.



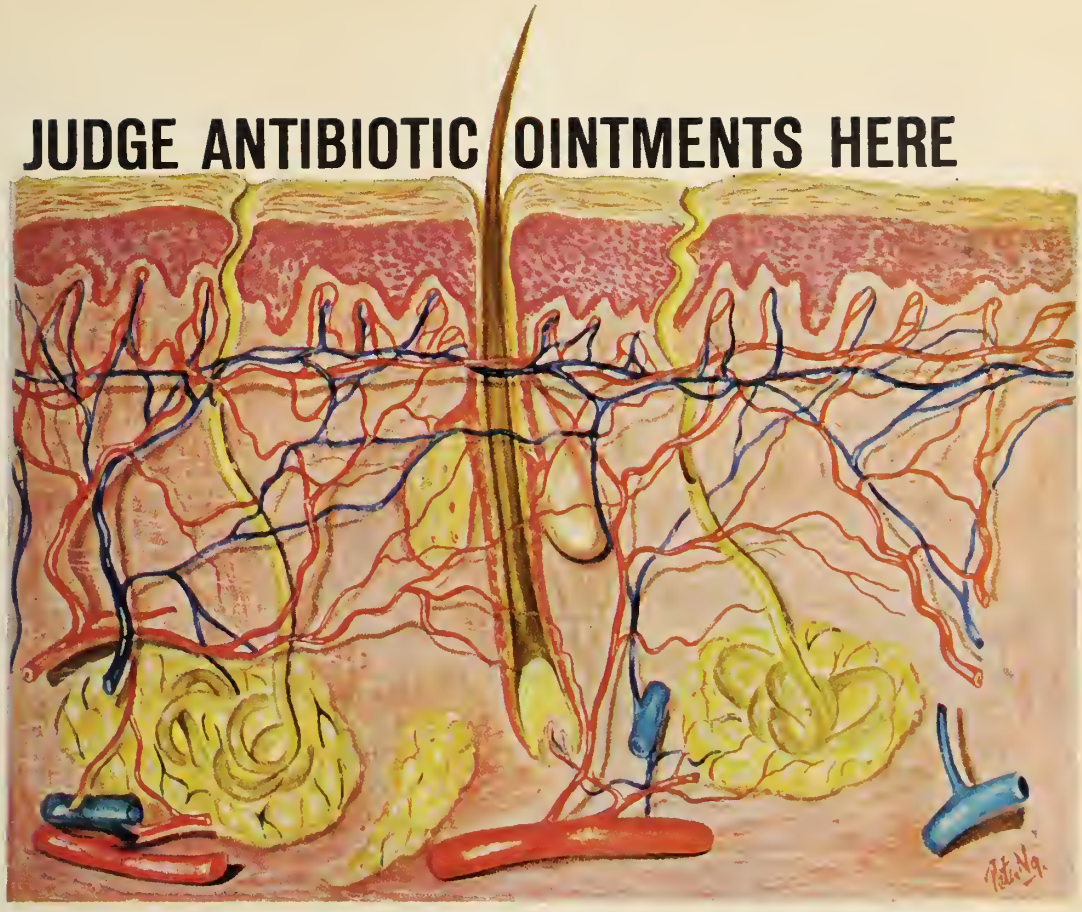
TUBERCULIN, TINE TEST (Rosenthal)

Side effects are possible but rare: vesiculation, ulceration, or necrosis at test site. Contraindications: none, but use with caution in active tuberculosis. Available in 5's and 25's.

Lederle

330–8/6135

JUDGE ANTIBIOTIC OINTMENTS HERE



Results on skin are final proof of any topical antibiotic's effectiveness

No in vitro test can duplicate a clinical situation on living skin. 'Neosporin' (polymyxin B – bacitracin – neomycin) Ointment has consistently proven its effectiveness in thousands of cases of bacterial skin infection. The spectra of the three antibiotics overlap in such a way as to provide bactericidal action against most pathogenic bacteria likely to be found topically. Diffusion of the antibiotics from the special petrolatum base is rapid since they are insoluble in the petrolatum, but readily soluble in tissue fluids. The Ointment is bland and nonirritating.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

Supplied: Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip.

Complete literature available on request from Professional Services Dept. PML.

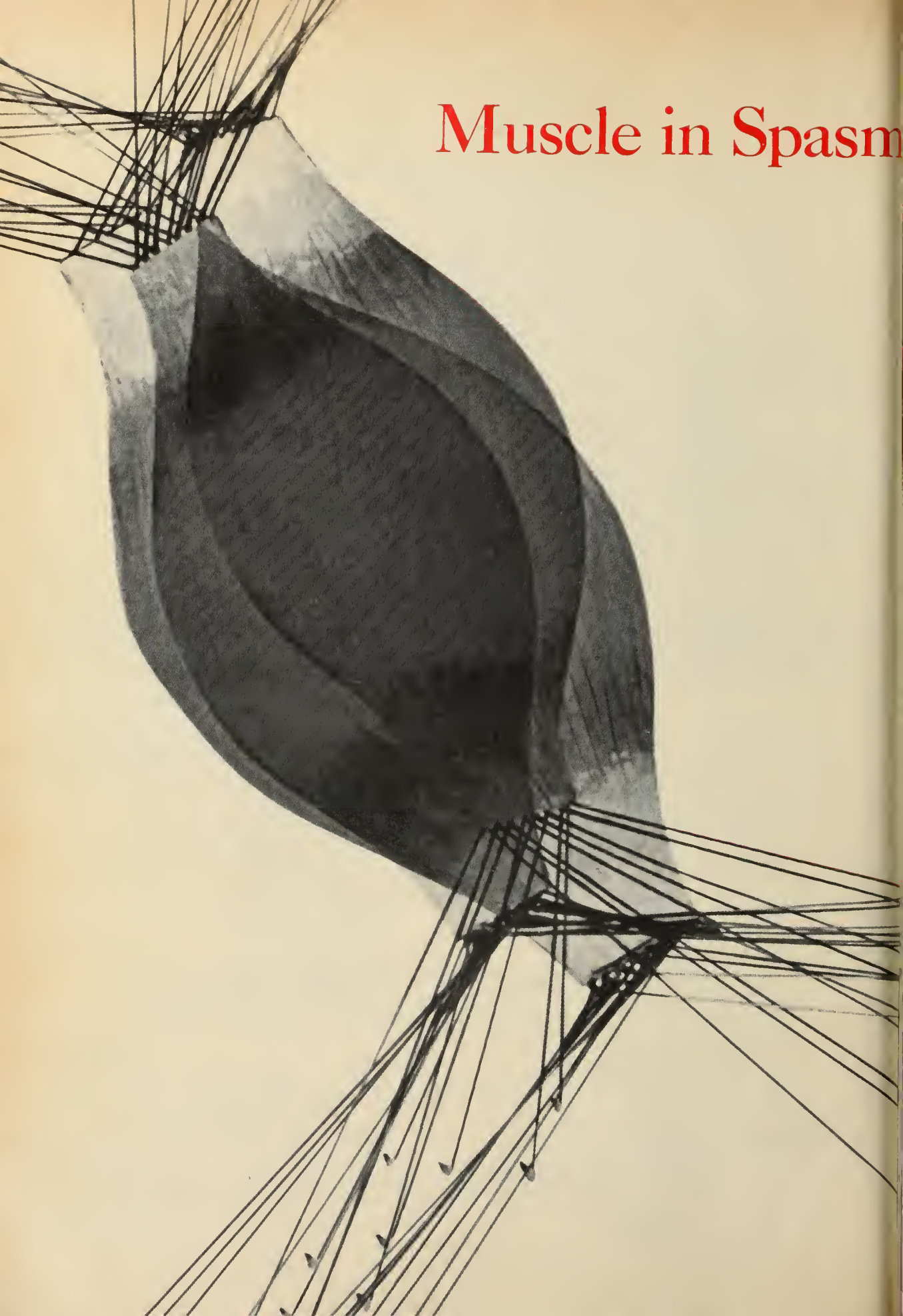
'NEOSPORIN'®

brand

POLYMYXIN B-BACITRACIN-NEOMYCIN OINTMENT

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

Muscle in Spasm



and Valium (diazepam)

The ability of Valium to help relieve skeletal muscle spasm—as well as psychic tension—demonstrates its clinical value and versatility.

The muscle-relaxant effect obtained with Valium, used adjunctively with other drugs or physiotherapy, favorably affects the entire cluster of spasm-related symptoms . . . helps accelerate return to normal activity.

When skeletal muscle spasm and psychic tension coexist, the calming effect of Valium is an added therapeutic benefit that contributes to the total management of the patient.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Valium®(diazepam)
2-mg, 5-mg, 10-mg tablets

ROCHE
Roche® LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110



Louie lost weeks with
a painful shoulder. That's a lot of fish.
It might have been different with **Butazolidin® alka**

100 mg. phenylbutazone
100 mg. dried aluminum hydroxide gel
150 mg. magnesium trisilicate
1.25 mg. homatropine methylbromide

If it doesn't work in a week, forget i

But please don't forget this:

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently. Large doses of the alka formulation are contraindicated in glaucoma.

Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Persistent or severe dyspepsia may indicate peptic ulcer; perform upper gastrointestinal x-ray diagnostic tests if drug is continued. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with caution in the first trimester of pregnancy and in patients with thyroid disease.

Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage occur. Make complete blood counts at weekly intervals during early therapy and at 2-week intervals thereafter. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The more common are nausea and edema. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately before or after meals or with milk to minimize gastric upset. Drug rash occasionally occurs. If it does, promptly discontinue the drug. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), or a generalized allergic reaction similar to serum sickness may occur and require permanent withdrawal of medication. Agranulocytosis can occur suddenly in spite of regular, repeated normal white counts. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity angiitis, pericarditis and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.



Dosage in Painful Shoulder: Initial: 3 to 6 capsules daily in 3 or 4 equal doses. Trial period: 1 week. Maintenance dosage should not exceed 4 capsules daily; response is often achieved with 1 or 2 capsules daily.

In selecting the appropriate dosage in any specific case, consideration should be given to the patient's weight, general health, age and any other factors influencing drug response. (B)P 46-070-A

For complete details,
please see full prescribing information.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

8U-5926

Butazolidin® alka Geigy

Capsules
100 mg. phenylbutazone
100 mg. dried aluminum hydroxide gel
150 mg. magnesium trisilicate
1.25 mg. homatropine methylbromide

Vital Statistics

NEW MEMBERS

Butler County

Davis, William Evans, b 34, mc Ala. 62, sb 62, L. V. Stabler Memorial Hospital, Greenville, Ala. 36037.

Franklin County

House, Roy Franklin, Jr., b 39, mc Univ. Tenn. 64, recip Tenn. 68, Red Bay, Ala. 35582. GP—356-4854.

Madison County

McCormick, Lonnie George, b 37, mc Univ. Tenn. 61, recip Tenn. 62, 905 Madison Street, Huntsville, Ala. 35801, R.—539-0457.

Wilson, Jack Wray, b 37, mc Univ. Tenn. 62, recip Tenn. 67, 401 Lowell Drive, Huntsville, Ala. 35801, Oph—536-7473.

Morgan County

Galloway, George Washington, Jr., b 33, mc Univ. Tenn. 58, recip Miss. 68, Hartselle, Ala. 35460, GP—773-2503.

Tuscaloosa County

Turpin, Delilah Little, b 37, mc Univ. Va. 63, recip Va. 67, Student Health Service, University, Ala. 35486. 35486, Pd.

MEMBERS REMOVED

Montgomery County

Britton, William Ross, 133 South Union St., Montgomery, Ala. 36104—deceased July 11, 1968.

Morgan County

Baugh, Wendell Phillip, 222 Gordon Drive SE, Decatur, Ala. 35601—deceased.

CHANGE OF ADDRESS OF MEMBERS

Butler County

Stabler, Ernest V., Jr., present Greenville, Ala. 36037, to 513 Claythorne Drive, Greenville, Ala. 36037.

Jefferson County

Doss, Faye W., present Birmingham, Ala. 35233, to 924 S. 19th St., Birmingham, Ala. 35205.

Moughon, William S., Jr., present Birmingham, Ala. 35205, to 1900-14th Avenue South, Birmingham, Ala. 35205.

Stabler, A. L., present Birmingham, Ala. 35211, to No. 6 St. Charles Avenue, Birmingham, Ala. 35211.

Morgan County

Chandler, John D., present Hartselle, Ala. 35640, to 5701 Mason Road, Memphis, Tenn. 38117.

Nash, James C., Jr., present Decatur, Ala. 35601, to 1306 Beech, Decatur, Ala. 35601.

Tallapoosa County

Shields, James, present Alexander City, Ala. 35010, to 2606-6th Court, Tuscaloosa, Ala. 35401.

Tuscaloosa County

Findley, Herbert L., Jr., present Tuscaloosa, Ala. 35401, to No. 12 Woodland Hills, Tuscaloosa, Ala. 35401.

CHANGE—TYPE OF PRACTICE

Macon County

Foster, Henry W., John A. Andrew Hospital, Tuskegee Inst., Ala.—ObG.

NEW TELEPHONE NUMBERS

Long, Robert T. L.—766-2630

NEW OFFICERS

WILCOX COUNTY

President—J. Paul Jones, M. D.

Secretary-Treasurer—W. R. Anderson, M. D.

BOARD OF CENSORS

James D. Nettles, M. D., Chairman
J. Paul Jones, M. D.
W. R. Anderson, M. D.
E. G. Burson, M. D.

57 State Scholarship Loans Approved
Nine Receive Merit Scholarships

The twin targets—providing financial help for the doctors of tomorrow and providing graduate MD's for the less populous areas of Alabama—are the aim of State Scholarship Loans, approved each year by the Board of Medical Scholarship Awards.

Fifty-seven such loans of "not exceeding $2,000 annually" each are currently announced, plus nine Merit Scholarships.

All but two of the loans are for medical studies at the University of Alabama in Birmingham. The exceptions are Garfield Grimmett of Tuskegee, a freshman, to attend Howard University Medical School, and Shirley Welch of Mobile, a sophomore at the University of Miami Medical School.

Twelve others who will become freshmen in medicine on Scholarship Loans are: Phillip Bobo, Raymond Bowman, Frank Lachina and William McClellan, all of Birmingham; Peyton Bryars and David Peterson, Mobile; Connie Chandler, Prattville; Bruce Day, Cullman; Donald Hawkins, Gadsden; Jerry Jackson, Hayden; Stanley Lockridge, Bexar; and Bobby Weathers, Garden City.

Thirteen others entering the University of Alabama's sophomore medical classes in Birmingham on Scholarship Loans are: Larry Bolton, Scottsboro; George Burton, Talladega; Robert Cosby, Birmingham; William Creighton, Elberta; John Dupree, Ashford; Charles Hollingsworth, Fayette; John Koors, Mobile; Robert Morris, Huntsville; John Olson, Fairhope; John Peasant, Talladega; Robert Phillips, Montgomery; Michael Sharpe, Tallassee; and Charles Wingard, Greenville.

Juniors with the help of State Scholarship Loans will be George Fisher and Samuel Sullivan, Birmingham; Gary Gross and James W. Smith, Athens; John Akridge, Hueytown; John Campbell, Lineville; Bry Coburn, Mobile; Samuel Miller, Cedar Bluff; Shepherd Odom, Auburn; James Rains, Montgomery; James Scarborough, Florence; and Philip Walton, Gadsden.

And the 18 seniors in medicine, each from a different town in Alabama are: Charles Conner, Highland Home; Roddy Cook, Dothan; Kenneth Copeland, Gadsden; William Edge, Jasper; Ronald Hilyer, East Tallassee; Bobby Holt, Remlap; Dewey Jones, Adger; Eddie Lamon, Muscle Shoals; Milton Lennicx, Robertsdale; Franklin Long, Canoe; Marilyn McRae, Montgomery; Gaylon McCollough, Birmingham; Philip Newton, Mobile; Ronald Olivet, Tuscaloosa; Milton Raines, Tuskegee; Martin Stallings, Hartford; Horace Thompson, Bynum; and William Walley, Guntersville.

As an incentive to take up residence in the less populous areas of Alabama, where the need for graduate physicians is greatest, the borrower may repay his loan by going to a community designated in advance by the Board of Medical Scholarship Awards.

In addition to the 57 State Scholarship Loans for the year 1968-69, the Board announces Merit Scholarships to three freshmen, Stephen Davis, Columbus, Ga.; Gary Petry and Cary Petry, Tuscaloosa; and to Sophomores Robert Davis, Columbus, Ga., and Richard Stein, Montgomery; to Juniors Raymond Lyrene, Silverhill, and Donald Stewart, Saraland; to Seniors Terry Cooper, Gadsden, and William Hill, Winfield.

The Scholarship Loans and awards program became law in 1965. Membership on the Board of Medical Scholarship Awards is composed of two members of MASA's Board of Censors, the Chairman of MASA's Board of Trustees, the Executive Officer of the State Board of Health, the Dean of the Medical College of Alabama or his designee, the Chairman of the Admissions Committee of the Medical College, and two members appointed by the Governor of Alabama for four-year terms, one of whom shall be a member of the State Senate, the other a member of the Alabama House.



Summation:
In addition to its primary indications for duodenal and gastric ulcer, Robinul Forte (glycopyrrolate) is indicated for other G-I conditions that may benefit from anticholinergic therapy. Robinul-PH Forte (glycopyrrolate 2 mg. with phenobarbital) is indicated when these situations are complicated by mild anxiety and tension.

Contraindications: Glaucoma, urinary bladder neck obstruction, pyloric obstruction, stenosis with significant gastric retention, prostatic hypertrophy, duodenal obstruction, cardiospasm (megaesophagus), and achalasia of the esophagus, and in the case of Robinul-PH Forte, sensitivity to phenobarbital.

Precautions: Administer with caution in the presence of incipient glaucoma.

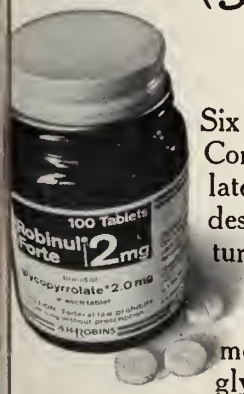
Adverse Reactions: Dryness of the mouth, blurred vision, urinary difficulties, and constipation are rarely troublesome and may generally be controlled by reduction of dosage. Other side effects associated with the use of anticholinergic drugs include tachycardia, palpitation, dilatation of the pupil, increased ocular tension, weakness, nausea, vomiting, headache, dizziness, drowsiness, and rash.

Dosage: Should be adjusted according to individual patient response. Average and maximum recommended dose is 1 tablet three times a day; in the a.m., early p.m., and at bedtime. See product literature for full prescribing information.

Supply: Robinul (glycopyrrolate 1 mg.); Robinul Forte (glycopyrrolate 2 mg.); Robinul-PH (glycopyrrolate 1 mg.) with phenobarbital 16.2 mg. (Warning: may be habit forming); Robinul-PH Forte (glycopyrrolate 2 mg.) with phenobarbital 16.2 mg. (Warning: may be habit forming), in bottles of 100 and 500 tablets. A. H. Robins Company, Richmond, Va. 23220.

A·H·ROBINS

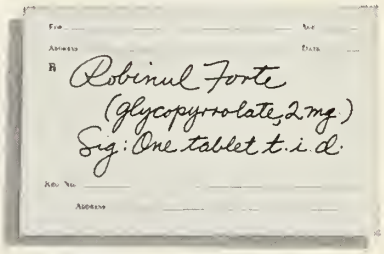
In peptic ulcer therapy, won't you give Robinul® Forte a Fair Trial?
(glycopyrrolate)



Six years ago the A. H. Robins Company introduced glycopyrrolate, a unique anticholinergic agent described in the prescribing literature as more closely approaching the ideal compound for controlling gastric hyperacidity and hypermotility of the G-I tract. Although glycopyrrolate (Robinul Forte) found good acceptance among numerous physicians, many others just didn't seem to want to give it a try, probably because the anticholinergic they were already using was giving acceptable results.

However, we believe you'll agree there's always room for a better anticholinergic. This is why we're asking you to give Robinul Forte a fair trial. Robinul Forte exerts a highly specific antisecretory action and marked inhibitory effect on intestinal tone. We're convinced you'll agree that this is indeed an outstanding drug when you observe its outstanding suppression of ulcer symptoms. Furthermore, it is unique in that it reduces intestinal tone, yet has little or no effect on peristalsis. In addition, the incidence of the more bothersome peripheral side effects is low.

No longer does the physician have to look for extreme dry mouth as the measure of his anticholinergic's effectiveness. The only way we can demonstrate to you firsthand the efficacy of glycopyrrolate (Robinul Forte) is for you to try it in your practice. That's why we're asking you to give it a Fair Trial. How can you give it a Fair Trial? You do it this way:



First: When you see your very next ulcer patient, write him a script as shown.

Next: Wait 10 days or until your patient comes in for his next appointment and get his "verdict" as to how he feels. Examine all the evidence and make your evaluation of his condition.



Finally: Render **your** verdict. If it's "significant improvement and marked relief of symptoms," then we believe you'll agree that Robinul Forte has proved its worth, and we rest our case. If not, consider our case for Robinul Forte closed. That's a Fair Trial, Doctor, and it's all we ask.

Robinul® Forte
(glycopyrrolate, 2 mg.)

The summation is an important part of every case. You'll find ours on the preceding page, Doctor.



The Month in Washington

From the Washington Office
American Medical Association

Washington, D. C.—"Improving the quality of life in this country requires that far greater national effort be devoted to reducing the incidence of preventable diseases, accidents and premature death."

This was the theme of a proposal to President Johnson to establish a Commission on Disease Prevention and Health Protection, appointed by the President, to make recommendations within a year.

The President was told that "to continue the present national emphasis upon treatment and after-the-fact remedies, as opposed to prevention, must be regarded as a failure of the health professions to adequately protect the public."

Said the plan's sponsors, headed by Sen. Warren Magnuson (D., Wash.), Chairman of the Senate Commerce Committee:

"Many of the diseases currently prevalent can be prevented entirely. Others can be detected and cured in the early stages. In some cases, it is simply a question of instilling awareness, recognizing symptoms or the importance of diet, and exercise. Technical personnel and automated laboratory and computerized recording procedures can utilize known techniques to operate comprehensive screening programs. These prevention and early detection programs can save money and conserve scarce physician time. People can be educated to expect health rather than to tolerate illness, to demand prevention rather than to admire belated treatment."

The statement continued:

"Benefits can be derived through legislation. Others will accrue through public and professional education. Still further benefits would come from financial support for special professional and non-professional training in the practice of preventive medicine. The following are just a few examples of things that can be done now. For example, we now have the authority to clean the polluted air over most of the major urban areas of this country.

"Other approaches include new methods of paying for and organizing health services. We, at present invest huge sums in medical care, through public and private support. The same means of coverage, however, such as Title XVIII, do not provide for 'health protection': there is no payment for periodic health appraisal on an out-of-hospital basis, with provision for follow-up care. This should include individual and group counselling services necessary for health maintenance, given by a physician or other health professional."

The Magnuson group said that "despite the convincing case for prevention, about two-thirds of all medical schools do not have departments of preventive medicine. This lack is appalling. We should at once encourage the establishment, or strengthening, of these departments in all medical schools, and emphasize a more realistic training program for the physicians of tomorrow."

* * *

The 1968 supplemental report on Smoking and Health of the Surgeon General of the Public Health Service reaffirmed that cigarette smoking is a health hazard.

The report was sent to Congress the same day as a Federal Trade Commission recommendation that cigarette advertising be banned from television and radio.

Highlights of the smoking report were:

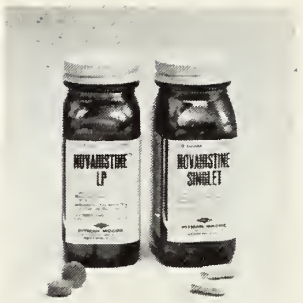
—New evidence indicating that the life

(Continued on Page 254)

Some U.R.I. patients are more miserable than others.

That's why we make Novahistine® tablets in two different formulations.

And let you control the dosage.



Each Novahistine LP tablet contains phenylephrine hydrochloride, 25 mg.; and chlorpheniramine maleate, 4 mg.
Each Novahistine Singlet tablet contains phenylephrine hydrochloride, 40 mg.; chlorpheniramine maleate, 8 mg.; and acetaminophen, 500 mg.

With Novahistine LP tablets and Novahistine Singlet™ tablets you have the range and flexibility of decongestant dosage that lets you prescribe for the needs of the individual patient.
Novahistine LP tablets are most useful for relief of nasal congestion in patients without pain or fever. Novahistine Singlet tablets, which provide analgesic-antipyretic effect, as well as decongestant action, are indicated for upper respiratory infections accompanied by pain, aches and fever.
Whether you prescribe Novahistine LP or Novahistine Singlet, a total daily dose of 3 or 4 tablets will usually provide effective, continuous relief.
Use cautiously in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

DOW PITMAN-MOORE DIVISION OF THE DOW CHEMICAL COMPANY, INDIANAPOLIS



"Nothing else I've tried seems to work, so I decided to give you a crack at it."

(Continued from Page 252)

expectancy among young men is reduced by an average of eight years in "heavy" cigarette smokers, those smoking over two packs a day, and an average of four years in "light" cigarette smokers, those smoking less than one half pack per day.

—Cigarette smoking can contribute to the development of cardiovascular disease and particularly to death from coronary heart disease. Some of the harmful cardiovascular effects appear to be reversible after cessation of cigarette smoking.

—New evidence that the previous finding that cigarette smoking is the most important cause of chronic bronchopulmonary disease in the United States.

—Additional evidence that cigarette smoking is a main cause of lung cancer in men and is casually related to lung cancer in women.

* * *

Dr. Robert Q. Marston was appointed to succeed Dr. James A. Shannon as director of the National Institutes of Health, effective Sept. 1.

Dr. Marston, 45, had been administrator of the NIH's Health Services and Mental Health Administration since April 1. He went with the NIH in 1966 as the first administrator of the Heart Disease, Cancer and Stroke Regional Medical Programs. Before that, he had been vice chancellor and dean of the University of Mississippi Medical School.

Dr. Marston, in accepting his new post, listed knowledge first and then money and manpower as the key factors in future improvements in the health of Americans.

"The ultimate constraint of our ability to effect the health of the people is neither dollars nor manpower, but the knowledge gained through research," he said.

"A major problem of the future will be to insure institutional stability, during times of manpower and fiscal shortages on which future (medical research) success is dependent."

In appointing Dr. Marston, President Johnson said the new NIH director faces a "staggering job" because not only the United States, but the entire world needs "rescue from death and disability that medical research promises."

* * *

President Johnson named a special committee to develop a five-year program for providing more effective birth control. The study committee will be headed by HEW secretary Wilbur J. Cohen, Mrs. John D. Rockefeller, III, N. Y., will serve as his co-chairman. An official said one matter to be studied would be the fact that present methods of contraception are not adequate. He said the so-called "pill" is too expensive for widespread use in some areas and it was difficult to educate illiterate people in its use.

* * *

The National Institutes of Health has asked processors of whole pooled human blood plasma to halt its interstate shipment because the substance has been causing hepatitis, an infection of the liver, in one out of 10 patients receiving transfusions. The move is expected to halt use of most such plasma of which about 300,000 pints are given annually to about 100,000 patients in the United States. The agency acted on a report issued in April by the National Research Council saying use of whole pooled plasma should be discouraged and even discontinued because of the hepatitis danger.

* * *

The Senate Health Subcommittee was told that the nation talks more and does less about its 5 million alcoholics than any of its other health problems. Michael Gorman, a spokesman for the National Council on Alcoholism, said that the losses from alcoholism are now running about $2 billion a year. Dr. Philip R. Lee, Health, Education and Welfare Assistant Secretary, supported Gorman. According to Dr. Lee, alcoholism was an "enormous economic liability to the nation" in terms of job absenteeism, lowered productivity, and medical insurance expenses.



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Parke, Davis & Company, Detroit, Michigan 48232

PARKE-DAVIS

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(Continued from Page 252)

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In tetracycline-sensitive bacterial infection complicating respiratory allergy, ACHROCIDIN brings the treatment together in a single prescription—prompt relief of headache and congestion together with effective control of the organisms frequently responsible for complications leading to prolonged disability in the susceptible patient.

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Contraindications: Hypersensitivity to any component.

Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.

Precautions: Drowsiness, anorexia, slight gastric distress can occur. In excessive drowsiness, consider longer dosage intervals. Persons on full dosage should not operate vehicles. Nonsusceptible organisms may overgrow; treat superinfection appropriately. Treat beta-hemolytic streptococcal infections at least 10 days to help prevent rheumatic fever or acute glomerulonephritis. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity* reactions—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

Upon adverse reaction, stop medication and treat appropriately.

Lederle

349-8

Regional Workshops To Be Held By Woman's Auxiliary To AMA

The Woman's Auxiliary to the American Medical Association will feature four regional workshops for state presidents, presidents-elect and committee chairmen during October. The purpose of the two-day meetings is to encourage and strengthen state participation in Auxiliary projects and provide an atmosphere for an interchange of ideas among state representatives.

Main topics to be discussed include the American Medical Association Education and Research Foundation, health careers, membership, safety-disaster preparedness, community health, mental health and program development. One or two AMA field representatives will attend to discuss across-the-board AMA programs.

Mrs. Frank Gastineau, member of the board of directors, American Medical Political Action Committee, will speak at the dinner meeting at each of the four workshops. In addition, an AMA field division representative from Washington will participate in each workshop dinner session.

Following is the workshop schedule: Denver, Colo., Oct. 7-8; New Orleans, La., Oct. 10-11; St. Louis, Mo., Oct. 14-15; and Boston, Mass., Oct. 17-18.

Calendar of Annual Meetings

Medical Association of the State of Alabama

1969, April 24-26, Carriage Inn, Huntsville

1970, April 30-May 2, Mobile

1971, April 22-24, Birmingham

1972, April 20-22, Montgomery

1973, April 18-21, Mobile



When eating fads of teens or tots Lead to a sudden case of "trots"

Parepectolin for quick relief of acute diarrhea
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... consolidates fluid stools with pectin
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In children, Parepectolin may be used to control diarrhea promptly and prevent dehydration, until etiology has been determined. In some cases, Parepectolin may be all the therapy necessary.

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Each fluid ounce of creamy white suspension contains:
*Paregoric (equivalent) ..... (1.0 dram) 3.7 ml.
Contains opium (¼ grain) 15 mg. per fluid ounce.
warning: may be habit forming
Pectin ..... (2½ grains) 162 mg.
Kaolin (specially purified) .... (85 grains) 5.5 Gm.
(alcohol 0.69%)
Usual Children's Dose: One or two teaspoonfuls three times daily.

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Ruling Issued on Transient Welfare Cases

The possibility that Alabama physicians can experience difficulty in receiving payment for services rendered to out-of-state welfare recipients arose several weeks ago when a North Alabama pediatrician reported that the Ohio Department of Public Welfare had declined to pay for treatment of two children unless he signed an "assurance of compliance with the Civil Rights Act of 1964 as required by federal law and regulation."

The physician referred the problem to the Association for an opinion and recommendation.

The Association's attorney, Mr. William Inge Hill, after conferring with Ohio Welfare authorities, ruled that the physician was within his rights and acted wisely in refusing to sign a form guaranteeing blanket future compliance inasmuch as Ohio law permitted him to obtain reimbursement under somewhat the same regulation applied to Alabama welfare cases.

In the belief that this situation may be repeated and that a knowledge of the facts would be helpful to members of this Association, the Board of Censors, at its July meeting, instructed that The Journal publish a resume of the complaint and attorney's opinion.

Briefly, the physician had stated the following case:

"On May 3, 1968, I treated, in my office, two children who were recipients of Public Welfare funds from the State of Ohio. A statement for $10 was duly submitted to the Ohio Department of Public Welfare, which was returned with the explanation that they were not in a position to pay the enclosed bills without the assurance of compliance with the Civil Rights Act of 1964 as required by federal law and regulation. Forms were enclosed for me to sign and re-submit, with my bill for payment, to assure my compliance with the law.

"I returned my bills, with the forms unsigned, and with a letter stating that I felt unable to sign a statement guaranteeing my compliance, since such a statement might be used in a self-incriminatory manner by others. I felt that they wished me to guarantee that I had not violated the law—in spite of the absence of any complaint that I had, whether from the recipient of my professional service, or others, or from legal authority. This requirement of a guarantee from me seems unique, and forms the basis of my letter. . . .

"It is my feeling that the law, if this is the

current interpretation, is illegal, and perhaps unconstitutional. The question, of course, does not concern itself with whether I show discrimination in my practice. I do not. I never have. But I object strenuously to anyone forcing me to guarantee that I do not. This is my professional practice, and I insist upon the right to conduct it in any manner I choose. (For the record, I maintain a single waiting room, appointments are made and patients are seen consecutively without bias, regardless of whom they may be—and this includes ability to pay. I've never turned a patient away, or discriminated against him in any manner because of his background or origin. I'm a physician first.)

"If an individual chooses not to seek medical service from me, this is certainly his privilege; but if I treat him with diligence and concern, he cannot then unilaterally alter the contract and refuse to compensate me.

"I read the comments by counsel for the Medical Association of the State of Alabama in the last (June) issue of The Journal, but they don't seem to cover the issues I raise.

"I feel this matter, which most physicians of our country must face sooner or later, requires the kind of deliberation which I do not possess. I would be exceedingly grateful for your opinions and recommendations."

Attorney Hill's reply follows:

"This letter is written in compliance with your request and in response to the inquiry received from (a member of this Association). . . .

"We were unsure of the exact context of the forms to which he referred, and hence were unable to render an opinion as to those forms. For this reason, we telephoned to the Department of Public Welfare in Ohio and there talked with Mrs. Florence M. Foster, who is supervisor of Health Care Accounts of the Ohio Department of Public Welfare. Mrs. Foster advised us the HEW plan to which Ohio subscribes provides that a physician furnishing medical care to welfare patients is entitled to receive compensation on either of two alternatives listed as follows:

"**1st Alternative:** A physician may sign a card which will provide assurance of future compliance with the Civil Rights Act of 1964 after which further statements from such physician will be accepted and processed. In other words, the physician would be placed on an approved list. We have not seen the card although one has been requested. However, we have no doubt from our conversation that a form of this kind could be made a basis for a compliance suit against a physician in the event he later fails to comply with the Civil Rights Act or he is charged with having failed to comply with the Civil Rights Act. Under the Alabama procedure adopted by Pensions and Security, this assurance form is not customarily signed by Alabama physicians performing services for Alabama welfare patients.

"**2nd Alternative:** A physician who has not signed the assurance form referred to in the 1st Alternative is entitled to receive payment for services rendered a welfare patient if on each statement which he forwards there is typed the following endorsement:

> **"Services were provided in full compliance with Title 6 of the Civil Rights Act of 1964 to the end that no person in the United States shall, on the ground of race, color, or national origin be excluded from participation in, be denied the benefit of, or be otherwise subjected to discrimination under any program or activity administered or supervised by the Ohio Department of Public Welfare."**

"The whole substance of the endorsement is incorporated in the first line and one-half and the balance is surplusage. It is a statement that the services for which payment is sought were provided in full compliance with Title 6 of the Civil Rights Act of 1964. This form is similar in context to the compliance form which Alabama physicians customarily sign in rendering state-

(Continued on Page 261)

Today you work harder
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Blue Cross-Blue Shield
of Alabama



(Continued from Page 259)

ments for services rendered to Alabama welfare patients. It does not assure further or future compliance with the Act, and does not carry with it the threat and implication of future enforcement litigation.

"If a member treats Alabama welfare patients and executes and signs the certificate which is attached to each statement, it would seem to us that the 2nd Alternative provided for in the Ohio plan would not be objectionable to him.

"There seems to be one significant difference between the 2nd Alternative in the Ohio procedure on the one hand and the Alabama procedure on the other. In Alabama we understand from the letter previously sent to the Medical Association by Mr. (Ruben) King that the failure of a physician to certify compliance with the Civil Rights Act on a medical statement would not bar payment of the statement. However, it would doubtless be a basis to disqualify the physician from further participating in the plan as a recipient of welfare medical payments. In Ohio the actual certification of compliance is a condition to the receipt of welfare medical payments by a physician even with respect to services already rendered. The disqualification is immediate rather than in the future. The Ohio procedure is, in our opinion, permissible and legal. No physician is required to perform medical services for Ohio welfare patients. On the other hand, no physician can legally require the Welfare Department in Ohio to pay for medical services rendered a welfare patient unless the conditions of the Ohio plan in one of the two alternatives have been fulfilled."



Joint Statement On Health Manpower

by the

American Medical Association

and the

Association of American Medical Colleges

Rising public expectations for health services and determination to upgrade quickly the health care of large segments of the population have created unprecedented demands for physician manpower. The public's challenge to medical education to respond by producing the necessary health manpower is clearly understood and has been accepted by the medical profession. At a second joint meeting of members of the AMA Board of Trustees and the Executive Council of the AAMC, these groups again expressed their determination to mobilize the support necessary for the medical schools to expand enrollments to desirable levels.

A medical college is a complex, multi-purpose enterprise with important obligations to various individuals, groups, organizations, and to society. It is impossible for a medical college to operate at a high level and to discharge these obligations without effective funding, planning, coordination, and control. Appreciation of the complexity of function and financing is necessary for any understanding of the fiscal predicament in which academic medical centers now find themselves.

At this time AMA and AAMC urge that increased emphasis be given to support of the educational component of academic medical center activities with the intent that the production of physicians and other health personnel by such centers be assigned the highest possible priority. In their effort to mobilize support for medical education, AMA and AAMC leaders resolve to use all of their resources to achieve the desired results.

The problems of each academic medical center are unique to that institution. A blanket solution nationally designed and centrally imposed will not produce desired results. Rather, the interests and talents of governing boards, the magnitude and sources of assured support, the abilities and goals of faculties, the hopes and ambitions of students, and the influence of local, regional, and national attitudes must all go into determining in what fashion each academic medical center can make its optimal contribution.

A. Increased Number of Graduates

1. Increased Enrollment

   Each medical school is examining carefully what it can do. In September, 1968 about 200 more students will enroll in the first year classes of all existing medical schools than in the fall of 1967. By 1969 another increase of over 400 is expected. Incentives should be devised to assist with increased construction funds and operating budgets those schools which elect to expand enrollment.

2. More Medical Centers

   In September, 1967, five new medical schools opened their doors, and in 1968 five others are expected to begin operation. Universities in cities with a combination of population density, a strong undergraduate school, availability of adequate land, appropriate clinical facilities, and a reasonable source of financial support have been and should continue to be strongly encouraged when they seek to organize medical schools.

B. Mobilization of Support

1. From Local Sources

   The AMA has asked its field staff to highlight the urgency of the manpower question before county and state medical societies. These societies have been asked to form committees to marshal

a response at city, county, and state levels aimed at increased production of health manpower in both privately and publicly owned medical schools.

2. From Private Sources

Private sources—individuals, industries, and foundations—remain as major contributors to the support of medical education. This fact must never be obscured by the prominence of federal and state tax support. Private support has allowed American medical education the flexibility which has made it strong. The AMA and the AAMC through the AMA Education and Research Foundation and the National Fund for Medical Education are joining forces to convince industry and the foundations that it is in their vital interest to encourage diversity in the support of American medical education.

3. From the Federal Government

Federal support for the educational component of medical center activity should be further encouraged. The full sums of money authorized under existing legislation should be appropriated. Both AMA and AAMC have testified repeatedly and will continue to testify before both Senate and House committees during the coming year. Their testimony is virtually identical in request for support for medical education linked to increased enrollments. Passage of the Health Manpower Act of 1968, which provides for funding for construction, operation and educational innovation in medical centers, is being strongly advocated by both Associations.

C. Other Specific Steps

In addition to the above-mentioned testimony before Congress for support of full appropriations for existing legislation, the call for passage of the Health Manpower Act of 1968, the development of local committees in state and county medical societies, and coordinated approaches to industry and other private sources, other measures are underway. Medical schools are (a) continuing to seek ways to enroll more students and to reduce dropout rates; (b) exploring methods for allowing entry into medical schools from many backgrounds, and at different levels; (c) organizing curricula which will permit progress through medical school at different rates; and (d) introducing measures to increase the educational effectiveness and productivity of medical schools. The modern medical curriculum, a continuum which includes college, medical school and the internship and residency years, is being examined with the objective of achieving optimal investment of the time of each student and faculty member.

The AMA and AAMC will continue to lend all of their support to a national program encompassing the features outlined in this statement.

• • •

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Contact

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Alabama Department of Public Health

Health Education And Community Development*

By

Robert A. Diseker

Health Educator, Tennessee Valley Authority

Education is a process by which attitudes are molded and modified by the presentation of new experiences and knowledge. As health educators we are agents of change, catalysts, who shape or prevent behavior by the modification of attitudes through the educational process. We are communicators of the technological advances in medicine and health services to the general population.

As communicators and educators we have a responsibility to gear our communication to the population whose behavior we are attempting to modify. This requires an analysis of the target population. We must determine factors influencing the behavior in question, notably those factors related to environment, education, and culture before attempting to develop a program of health education.

Too often, as health educators we have omitted this analysis in our preoccupation with the development of tools and techniques to enhance the educational process. In our overzealousness we have often entertained rather than educated our target population. We have made converts of the more credulous, but an honest evaluation of many "health education" programs would find their results to be ephemeral at best.

Change requires conscious and/or subliminal involvement, a recognition of the shortcomings of the behavior in question, and modification or replacement of this behavior. Many avenues of change are open to us as educators, but it is not within the scope of this paper to dwell on these. It is enough for our purposes to recognize that our approach should be determined by an analysis of the target population.

As the behavior of our target population is modified, the characteristics of this population undergo change. This requires meaningful reexamination and evaluation. We can't continue to keep on keeping on! We must evaluate and tailor our program to meet the needs of this changing population. We must continually strive to overcome our shortcomings and build a better program.

Instruments for the evaluation of health education programs are noticeably lacking, and too often we find evaluation reduced to a mere numerical tally of converts to or from a particular kind of behavior. As health educators we have an obligation to our pro-

(Continued on Page 267)

*Presented before the Quarterly Conference of Alabama Health Educators, Ann Jordan Farm, Alabama, July 25, 1968.



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hyoscine hydrobromide	0.0065 mg.	0.0065 mg.	0.0195 mg.
phenobarbital	(¼ gr.) 16.2 mg.	(½ gr.) 32.4 mg.	(¾ gr.) 48.6 mg.
(Warning: may be habit forming)			

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Brief summary. Blurring of vision, dry mouth, difficult urination, and flushing or dryness of the skin may occur on higher dosage levels, rarely on usual dosage. Administer with caution to patients with incipient glaucoma or urinary bladder neck obstruction. Contraindicated in acute glaucoma, advanced renal or hepatic disease or a hypersensitivity to any of the ingredients.

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Write "30" for B and C deficiencies. This handy bottle of 30 Allbee with C capsules gives your patient a month's supply at a very reasonable cost. Also the economy size of 100. Available at pharmacies on your prescription or recommendation.

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30 Capsules
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Each capsule Contains:

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Pyridoxine hydrochloride (Vit. B_6)	5 mg
Niacinamide	50 mg
Calcium pantothenate	10 mg
Ascorbic acid (Vit. C)	300 mg



(Continued from Page 264)

fession to come to grips with the problem of evaluating health education programs. This health education section could give impetus to the consideration of this question and change the model for the examination and evaluation of health education programs.

Let's turn now to the role of health education as a function of the overall development of communities by examining problem solving ability as an indicator of community development.

You don't remember your first problem, but it was related to the basic bodily functions of eating, sleeping, or eliminating and someone else solved it for you. As you grew and had new experiences, your problems became less self centered and became more and more directed toward your relationships with society. You depended less on others for direct solutions to your problems and began to become more competent in your problem solving ability. As your ability to successfully determine solutions to problems evolved, the level of sophistication of the problems facing you was raised. This phenomenon, the evolution of problem solving ability in the child, is roughly analogous to the process that governs the development of communities, regions, and nations.

If an individual's or community's problems could be represented graphically in the shape of a triangle we would see triangles of varying sizes, depending on the degree of sophistication of the problems confronting an individual. A scale alongside would indicate the level of sophistication of an individual's problem solving ability and this would correspond directly with that individual's or community's level of development. We see a direct relationship; as we raise the problem solving ability, we raise the level of develop-

(Continued on Page 270)

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Assistant Professor of Psychiatry and Medical Director
Area Code 704 - 253-2761



Tandearil® in Osteoarthritis
oxyphenbutazone

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently.
Warning: Tandearil is an analog of phenylbutazone; sensitive patients may be cross-reactive. If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Persistent or severe dyspepsia may indicate peptic ulcer; perform upper gastrointestinal x-ray diagnostic tests if drug is continued. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with caution in the first trimester of pregnancy and in patients with thyroid disease.
Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia), sudden weight gain (water retention), skin reactions, black or tarry stools or other evidence of intestinal hemorrhage occur. Make complete blood counts at weekly intervals during early therapy and at 2-week intervals thereafter. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.
Adverse Reactions: The more common are nausea and edema. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension, the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reacti-

Pain Break" for an osteoarthritic.

Tandearil can usually ease it.

At 46, her knees still look good on the outside. But inside, there may be the familiar picture of osteoarthritis.



If aspirin doesn't help, Tandearil often will. Pain and stiffness begin to ease up in 3 or 4 days. You can often maintain response with a daily dose of only 1 or 2 tablets.

Of course, Tandearil is not for every osteoarthritic. Select your patients carefully and follow them in line with the Contraindications, Precautions, Warning, and Adverse Reactions listed below.

But for many aspirin-stubborn osteoarthritics, let Tandearil ease the unwelcome pain breaks of osteoarthritis.

Tandearil®
oxyphenbutazone

te a latent peptic ulcer. The patient should e instructed to take doses immediately after eals or with milk to minimize gastric upset. ug rash occasionally occurs. If it does, omptly discontinue the drug. Agranulocysis, exfoliative dermatitis, Stevens-Johnson ndrome, Lyell's syndrome (toxic necrotizg epidermolysis) or a generalized allergic action similar to a serum sickness syome may occur and require permanent ithdrawal of medication. Agranulocytosis an occur suddenly in spite of regular, reeated normal white counts. Stomatitis, saliary gland enlargement, vomiting, vertigo and nguor may occur. Leukemia and leukemoid eactions have been reported. While not defitely attributable to the drug, a causal relaonship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity, angiitis, pericarditis and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

For complete details, please see full Prescribing Information.

Geigy

Dosage in Osteoarthritis: Initial: 3 to 6 tablets daily in divided doses. Usually unnecessary to exceed 4 tablets daily. A trial period of one week is considered adequate to determine the therapeutic effect of the drug. Maintenance: Effective level often achieved with 1 or 2 tablets daily, should not exceed 4 tablets daily. In selecting appropriate dosage in any specific case, consideration should be given to the patient's weight, general health, age and other factors influencing drug response. Availability: Tan, round, sugar-coated tablets of 100 mg. in bottles of 100 and 1000.

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Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
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TA-5806AR

Diarrhea

TROCINATE® 400 MG.
BRAND THIPHENAMIL HCl.

The relief received from the first Trocinate 400 mg. tablet is so prompt that the discomfort of diarrhea ceases to be a bother. May be repeated every four hours.

Upon request, a supply of Trocinate 400 mg. with literature will be sent to physicians for their personal use.

WM. P. POYTHRESS & CO., INC.
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Manufacturers of ethical pharmaceuticals since 1856

(Continued from Page 267)

ment to a corresponding degree by opening new avenues of self help to the community or individual.

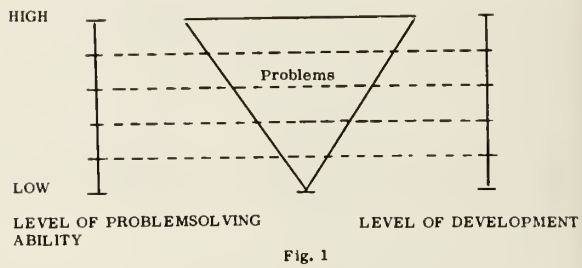


Fig. 1

This process is easily shown when causes of death in developing and developed countries are contrasted. Developing countries are for the most part struggling to keep people alive, fighting diseases which have been eliminated or reduced to the point of insignificance in developed countries. On the other hand, developed countries are facing diseases of nebulous etiology, requiring far more sophisticated research and treatment. As a country develops, this pattern of d'sease changes and comes to resemble that of developed countries. As the patterns change, so techniques must also change. More sophisticated problems demand a more sophisticated approach.

Public health workers are witnesses to this process today. Comprehensive health planning is a product of the evolution of public health. It is by no means a panacea, it is a legitimate descendent of the maturation of the problem solving process in our society. As such, we are obligated to examine it, use it, evaluate it and modify it as our needs change. We have broadened our horizons and begun to think of health in light of the World Health Organization's definition.

We seek answers to regional problems with regional solutions; we use the term problemshed. We speak of a problemshed as the geographic boundaries within which the most

effective and efficient solution to a common problem or problems might be realized. It is a community of solution, and it does not necessarily coincide with the boundaries of any political jurisdiction. This concept is seen by example when adjoining towns in neighboring states formulate and enforce air pollution agreements or when several counties join hands to support a regional health program.

Consider a program of community development as a means of raising the level of problem solving ability within a community of solution. Fred Wale, Director of the Puerto Rican Community Education Program defines community development thusly:

"Community Development is an Educational process. It is this, first, last and all the time. All else is secondary to it and must take its place as reflection and not as the end result. 'Community Development' is not better roads, better beehives, pure water or sanitary privies. It is something of the spirit and not something material. It must reach into the deep, cultural patterns of people, examining them and testing them as principles of faith. It is not a temporary, physical construction. It is a building within the hearts and minds of men, not a recreation center in the middle of a playground. It is these things because without them it matters relatively little whether the road is paved or not, whether you go to the woods or the sanitary privy, whether economically you and your community are materially blessed. It is these things because with them, all physical solutions follow in their order." [1]

The term *Community* Development has as its mother the term, *Community* Organization. Key ingredients of community organization are social welfare and adult education.

Social welfare might include social legislation, social planning and the activities of charitable organizations, while adult education has a legitimate interest in health education and is an integral part of community development.

Community *Development* is surnamed by Economic *Development* which is directly concerned with raising the standard of living. Examples of this are by increased producer efficiency in agriculture and industry, economic planning and the social changes which accompany these economic transfusions.[2]

Within the Tennessee Valley, a total resource development program was initiated in an effort to apply the process of Community Development to a geographic area including segments of seven states, 41,000 square miles, and 3½ million people. In many instances the entire valley serves as a community of solution, but in other examples local problems are examined within the framework of a smaller problemshed area, the watershed. A watershed, in this case is defined by the peripheral geographic boundary of a drainage area for a tributary of the Tennessee River. There are shortcomings in attempting to determine regional communities of solution by geography, but administratively these watersheds have worked well.

The Bear Creek Watershed may be classified as typical of the 19 watersheds in the Valley for our purposes today. It is a drainage area enclosing 936 square miles and approximately 35,000 people. There are 11 incorporated towns in the watershed ranging in size from less than 200 to 6,600 in population. The extreme distance between towns in the watershed is 70 miles. Within the watershed an association of citizens has formed eight committees or workgroups and is working with state and federal agencies to develop eight resource areas. For the next few minutes we will examine the role of one of the groups, the health workgroup, in the overall process of community development.

Historically, the health workgroup was composed of members representing each of the towns in the watershed, who met periodically to discuss and work on health problems of common concern. Several pro-

(Continued on Page 273)



NEW! THE RITTER COAGULATOR

from the makers of the famous Bovie electrosurgical units . . .

The Ritter Coagulator is a low-in-cost but high-in-quality electrocoagulation instrument for wall or shelf service in your office. Made by the makers of the famous hospital Bovie, it has been engineered to utilize every advantage of today's advanced state of electronic circuitry. It will coagulate, desiccate and fulgurate—and you can handle scores of day-to-day applications in dermatology, gynecology, rhinolaryngology and proctology. Easy, safe to operate. Compact—only 8½ x 5 x 4 inches. Ask for a demonstration.

DURR

Surgical Supply Co.

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(Continued from Page 271)

jects of interest to the entire region were promoted with varying degrees of success.

In assessing the effectiveness of this workgroup it was evident that the members were at different stages of readiness to comprehend the concept of a regional solution to problems. It was difficult for any member to look beyond the boundaries of his community to regional problems, and with good reason. They were at correspondingly different levels of development. While one community was initiating a federal grant proposal for a sewer system, another town exhibited little concern with sewage draining into open ditches in the heart of town. In fact, in one town a pit privy regularly overflowed into the back door of the post office when the water table rose sufficiently and a later survey indicated that 31 per cent of the toilet facilities in this town were unsanitary.

It was evident that the problemsheds would have to be shrunk until they were of comprehensible size. This was done. Local workgroups were organized in six of the towns; and local people began to work on problems that were important to them, at a pace commensurate with their abilities. A regional workgroup was formed that consisted of a chairman and each of the chairmen of the local subgroups. In this way information is shared among the local groups, they are stimulated to move in new directions and technical assistance is provided by workgroups when a group undertakes a project that has been previously experienced.

This sharing of information between towns has had several benefits; the sharer has a degree of pride in being able to share his accomplishments with others and the recipient often omits several stages in the trial-and-error process. In this sharing the beginnings of the regional development concept are imparted to the cooperators.

Following this relationship, it is easier to discuss problems of regional significance. Our groups are closer together in terms of readiness; they are looking beyond the boundaries of their communities; regional development is not the abstract term that it once was.

During the last year many changes have been wrought in towns participating in this program; in one town 15 per cent of the town's toilet facilities have been replaced with bathrooms; another town is presently operating the only sanitary landfill in northwest Alabama; a third town has established mandatory garbage pickup; while a fourth has set up a workable program and conducted a neighborhood analysis during the process of obtaining additional public housing units.

At a work planning meeting for the coming fiscal year the regional workgroup decided to demonstrate the sanitary landfill to representatives of all of the cities in the watershed and to conduct a watershed-wide carbon monoxide screening program in schoolbusses. We are beginning to grasp the abstract concept of region and to enlarge our problemsheds.

At this stage subjective evaluation indicates that some modification is needed in our program. We must grow with our problems and refine our skills to keep pace with the ever changing picture of community health. We cannot be content in this program or in any health education program to rest upon the past. As health educators we have an obligation to evaluate and modify, to overcome the muse of satisfaction, to meet head on the problems of tomorrow.

References

1. Wale, Fred. "A Program of Community Development," Health Educators at Work, Vol. II, 1961. P. 39.

2. Sanders, Irwin T. "Theories of Community Development," Rural Sociology, Vol. 23, No. 1, March 1958. Reprint, P. 2.

anticostive* hematinic



PERITINIC®

Hematinic with Vitamins and Fecal Softener

A tablet-a-day provides:

● Elemental Iron (as Ferrous Fumarate)	100 mg
● Dioctyl Sodium Sulfosuccinate (to counteract constipating effect of iron)	100 mg
Vitamin B_1	7.5 mg
Vitamin B_2	7.5 mg
Vitamin B_6	7.5 mg
Vitamin B_{12}	50 mcgm
Vitamin C	200 mg
Niacinamide	30 mg
Folic Acid	0.05 mg
Pantothenic Acid	15 mg

Bottles of 60

*

anticostive, *adj.* (*anti* opposed to + *costive* causing constipation.) Against constipation. Now isn't that a good idea in an iron-containing hematinic?

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BUREAU OF PREVENTABLE DISEASES

W. H. Y. Smith, M. D., Director

Current Morbidity Statistics

1968

	June	July	*E. E. July
Tuberculosis	126	116	142
Syphilis	70	109	145
Gonorrhea	384	526	381
Chancroid	0	0	2
Typhoid fever	0	0	1
Undulant fever	0	0	0
Amebic dysentery	1	0	4
Scarlet fever & strep. throat	350	255	48
Diphtheria	0	0	1
Whooping cough	3	18	13
Meningitis	4	5	3
Tularemia	0	0	0
Tetanus	2	0	2
Poliomyelitis	0	0	0
Encephalitis	0	0	0
Smallpox	0	0	0
Measles	13	11	82
Chickenpox	14	4	16
Mumps	50	28	30
Infectious hepatitis	18	15	53
Typhus fever	0	0	0
Malaria	3	1	0
Cancer	1,371	1,028	655
Pellagra	0	0	1
Rheumatic fever	16	9	16
Rheumatic heart	22	13	25
Influenza	17	5	20
Pneumonia	259	165	167
Rabies—Human cases	0	0	0
Pos. Animal heads	1	2	0

As reported by physicians and including deaths not reported as cases.

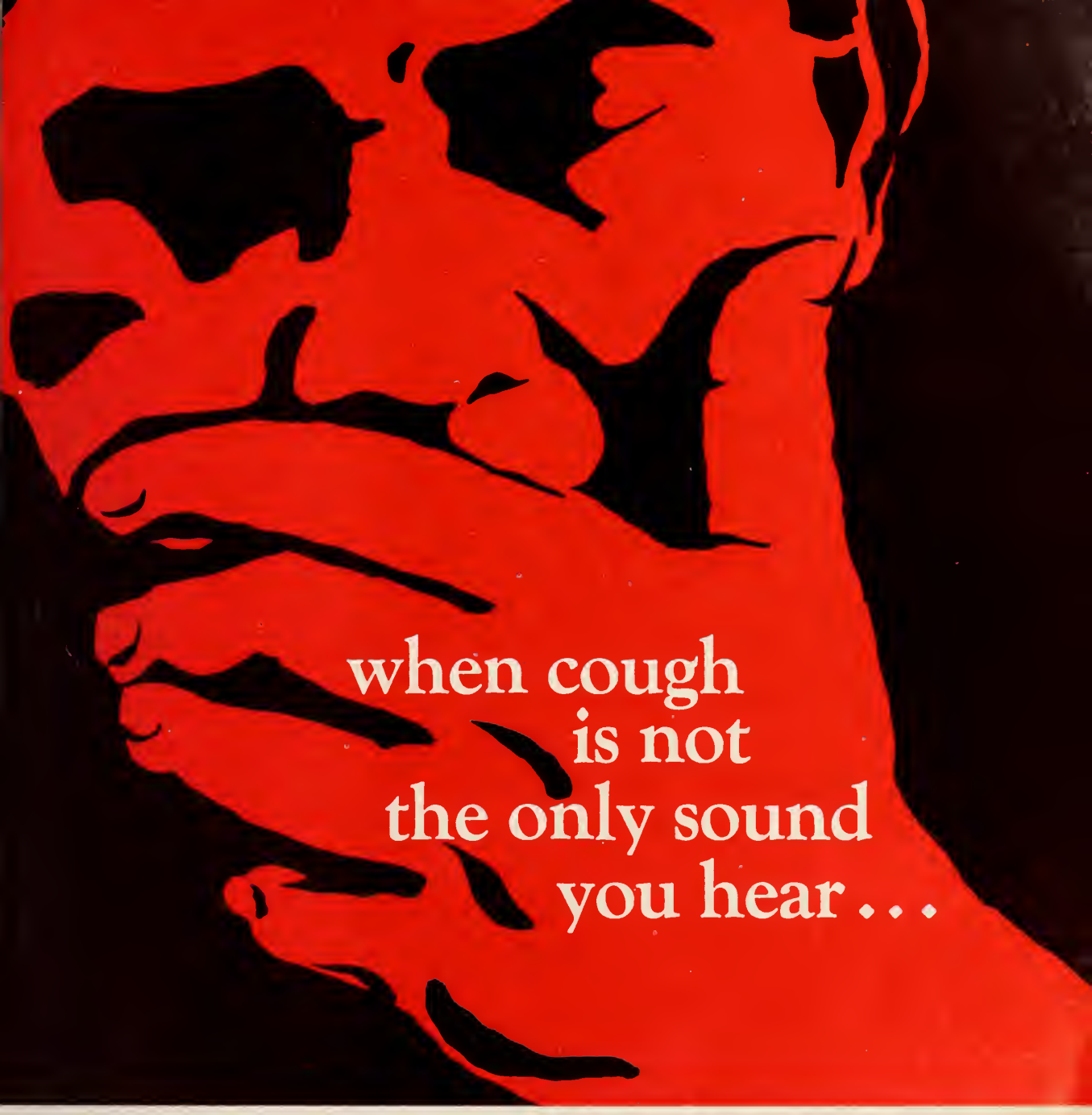
*E. E.—The estimated expectancy represents the median incidence of the past nine years.

BUREAU OF LABORATORIES

Thomas S. Hosty, Ph.D., Director

JULY 1968

Examination of Intestinal Parasites	1,545
Examination of Malaria	3
Examination for Salmonella & Shigella (blood-feces-urine-food)	314
Examination of tubercle bacilli	4,406
Examinations for gonococci	2,221
Serological tests for Syphilis	31,638
FTA	79
Darkfield	2
Brucella	0
General Bacteriology (cultures for isolation and confirmation)	20
Staphylococcus (cultures for isolation and confirmation)	1
Examinations for diphtheria (cultures for isolation and confirmation)	4
Streptococci examinations	1,669
Mycology	44
Agglutinations	23
Vincent's infection	2
Complement fixation tests	200
Tests for Phenylketonuria (PKU)	6,818
Cytology	2,007
Water examinations	3,796
Milk and dairy products examinations	5,475
Sea food examinations	96
Examinations for Negri bodies (smears & animal inoculations)	323
Virology	19
Rh Factor Bloods	735
Miscellaneous	2,439
TOTAL	63,879



OMNI-TUSS® b.i.d.

. . . **because** OMNI-TUSS is indicated for cough associated with upper respiratory tract infections, bronchitis, bronchiectasis, bronchial asthma, emphysema, sinusitis and rhinitis, hay fever, or other allergic conditions. Any of these conditions may exhibit the general symptom syndrome—coughing, wheezing, bronchospasm, and tenacious mucus—which may benefit from the antitussive, bronchodilative, antihistaminic, and expectorant action of Omni-Tuss.

The therapeutic usefulness of Omni-Tuss is enhanced by a unique resin complex formulation providing the clinically desirable advantages of: (1) uniform drug availability throughout an extended period, (2) 8 to 12 hours of symptomatic control, (3) minimal dosage requirement, (4) minimal side effects.

Economical, efficient **b.i.d.** dosage—extremely well-tolerated by children, 6-12, and adults.

'Omni Tuss' Suspension: Each teaspoonful (5 cc.) contains 10 mg. codeine (Warning: May be habit-forming), 5 mg. phenyltoloxamine, 3 mg. chlorpheniramine, 25 mg. ephedrine, all as cation exchange resin complexes of sulfonated polystyrene, and 20 mg. guaiacol carbonate.

Available on prescription only. Class X exempt narcotic. Permissible on oral prescription.

Dosage: *Adults:* 1 teaspoonful (5 cc.) q12h.
Children (6-12 *years*): ½ teaspoonful q12h.

Side Effects: Minimal, but when encountered may include jitteriness, nausea, drying of mouth, insomnia, constipation, which disappear upon adjustment of the dose or discontinuance of treatment.

Precautions and Contraindications: For complete detailed information, refer to package insert or official brochure.

Strasenburgh

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new evidence for TAO® (triacetyl-oleandomycin)



a
macrolide
antibiotic for the
frequently seen
respiratory infection
in the office
and
for a problem pathogen*
in the hospital.

*Staphylococcus aureus

study I[1]

Results of a 1967 in vitro—in vivo correlation study involving 116 patients with Gram-positive coccal infections in five institutions. All patients were given TAO prior to determining the susceptibility of the offending organism.

97.0%
of the organisms were susceptible to oleandomycin*

98.0%
of the patients responded favorably to TAO® (triacetyloleandomycin)

*In some cases more than one pathogenic organism was isolated from the patient.

study II[2]

Effect of oral therapy with TAO, erythromycin, and cloxacillin on the survival time of Rhesus monkeys after intravenous inoculations of lethal doses of staphylococci, phage type 80/81. (8 monkeys in each group)

conclusion:

*Under the conditions of this study and the doses employed, it was found that

TAO® (triacetyl-oleandomycin)

was far superior to erythromycin, as was cloxacillin, a bactericidal agent, and of particular interest, "...bacteriostatic triacetyloleandomycin was as effective or perhaps superior to cloxacillin in preventing lethal (staphylococcal, phage type 80/81) infection."

*It should be pointed out that results obtained in an experimental study of this nature may not necessarily be directly extrapolated to the clinical situation as it pertains to man.

TAO Rx Information

INDICATIONS: Include streptococci, staphylococci, pneumococci and gonococci. Recommended for acute, severe infections where adequate sensitivity testing has demonstrated susceptibility to this antibiotic and resistance to less toxic agents. **CONTRAINDICATIONS AND PRECAUTIONS:** Not recommended for prophylaxis or in the treatment of infectious processes which may require more than ten days continuous therapy. In view of the possible hepatoxicity of this drug when therapy beyond ten days proves necessary, other less toxic agents should be used. If clinical judgement dictates continuation of therapy for longer periods, serial monitoring of liver profile is recommended, and the drug should be discontinued at the first evidence of any form of liver abnormality. When treating gonorrhea in which lesions of primary or secondary syphilis are suspected, proper diagnostic procedures, including darkfield examinations, should be followed. In other cases in which concomitant syphilis is suspected, monthly serological tests should be made for at least four months. Contraindicated in pre-existing liver disease or dysfunction, and in individuals hypersensitive to the drug. Although reactions of an allergic nature are infrequent and seldom severe, those of the anaphylactoid type have occurred on rare occasions. When used in streptococcal infections, therapy should be continued for ten days to prevent the development of rheumatic fever or glomerulonephritis. The use of antibiotics may occasionally permit overgrowth of nonsusceptible organisms. A resistant infection or superinfection requires re-evaluation of the patient's therapy. In the event such occurs with this drug the medication should be discontinued, and specific antibacterial and supportive therapy instituted.

References: 1. Isenberg, H. D.: Clinical Evaluation of Laboratory Guidance to Antibiotic Therapy; Health Laboratory Science (July) 1967. 2. Saslaw, S., Carlisle, H. N.: Studies on Therapy of Staphylococcal Infections in Monkeys. 1. Comparison of Cloxacillin, Triacetyloleandomycin and Erythromycin. Proc. Soc. Exp. Biol. & Med.: Vol. 125, No. 4 (Aug.-Sept.) 1967.

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In the complex picture of moderate to severe anxiety...



there is a new reason for prescribing Mellaril (Thioridazine HCl)

effectiveness in mixed anxiety-depression

Long recognized for its usefulness in the treatment of moderate to severe anxiety, Mellaril is now also known to be effective against mixed anxiety-depression.

Often the symptoms of anxiety states are difficult to sort out—even with the most careful probing. The patient may manifest symptoms of agitation, restlessness, insomnia, somatic complaints. But what of the depression that may be mixed in the total picture? It is reassuring to know that Mellaril may be prescribed—with strong possibilities of success—when there is anxiety alone or a mixture of anxiety and depression.

Before prescribing or administering, see Sandoz literature for full product information, including adverse reactions reported with phenothiazines. The following is a brief precautionary statement.

Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.

Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when necessary.

Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving). Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascular System*—Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers, including Mellaril (thioridazine hydrochloride). While there is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients previously showing electrocardiographic changes. The use of periodic electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. *Other*—A single case described as parotid swelling.

Mellaril®
(Thioridazine HCl)
25 mg. t.i.d.

for moderate to severe anxiety and mixed anxiety-depression

SANDOZ SANDOZ PHARMACEUTICALS, HANOVER, N. J. 68-16

Infant Death In Alabama

George Cassady, M. D.

Birmingham, Alabama

For the past ten years, infants born in Alabama, black or white, have had less chance of survival than in any other state. Despite the reassuring decline in maternal mortality noted last year by Dr. Klingler, "Alabama—Safest Place to Have a Baby," infant mortality in Alabama (30 deaths per 1000 live births) continues to exceed that of the remainder of the country. The long list of *nations* where the chance of survival after live birth is better includes such surprises as Russia (27 infant deaths per 1000 births), Japan (19 infant deaths per 1000 births), and France (22 infant deaths per 1000 births).

Physicians are correctly cautious about misapplication of statistics realizing how easy it is to remove them from their proper context. There are certain reasons for these figures, undoubtedly beyond the control of physicians of this state. The time, however, has come for action and not excuses. The political trick of appointment of a "committee" to cure a problem has unfortunately been in use for many years by Alabama physicians as their "solution" to the problem of excessive infant mortality in Alabama. Presence of a Maternal and Infant Health Committee confirms the existence but does not correct this problem of excessive infant mortality in our state.

Several common misconceptions require correction:

(1) Infant mortality is *not* an irreducible minimum in this state—the high mortality is *not* explained away by racial or socio-economic conditions. For example, a 20 per cent reduction in perinatal mortality has been recorded in a single year (1967) at the University of Alabama Hospital despite a proportionate *increase* in Negro, indigent and complicated deliveries at this institution. Similarly, a 27 per cent decline in neonatal mortality in low birth weight babies (weighing less than 5½ pounds at birth) was concurrently recorded at the same institution.

(2) Infant mortality does *not* represent removal of the less fit from a society they will be unable to contribute to. Instead, perinatal and infant mortality represents merely the "top of the iceberg"—the measurable, visible portion of birth damage. The unseen, poorly-measured portion represents the damaged and the maimed; potential *contributors* transformed to dependents. The true tragedy of perinatal mortality is not the 1200 neonatal or 1700 infant deaths in Alabama in 1967 (two to three times this state's total Vietnam losses) but instead the uncounted thousands in whom birth asphyxia, trauma, or improper neonatal or infant care has resulted in permanent impairment or damage and whose existence in our present society will burden future generations of this state. Reduction of perinatal and infant *mortality* reflects improved medical attention for *the very same* problems that also produce permanent and disabling damage to the individual.

(3) Concern with perinatal mortality goes hand in hand with attention to "planned parenthood." The fact has been repeatedly confirmed that the family containing damaged children or experiencing excessive infant mortality, regardless of race or socio-economic status, is ultimately significantly larger than unaffected families. Concern with intelligent family planning must be

Dr. Cassady is Associate Professor and Director of Newborn Division and Newborn Nurseries at the University of Alabama Medical Center.

State of Alabama - Maternal and Child Health Committee - Perinatal Death Report

To be completed for all stillbirths if 28 weeks or more of gestation or if more than 999 grams birth weight and for all live-births who expire during the first 28 days of life.

Birth Date: / / ____AM ____PM

Death Date: / / ____AM ____PM

Birth wt. (g) ____

Length (cm) ____

Head circ. (cm) ____

Physician: ____

Hospital: ____

City: ____

County: ____

Negro ☐ White ☐ Other ☐

Twin #1 ☐ Twin #2 ☐ Other ☐

Neonatal death ☐ Fetal death ☐

Male ☐ Female ☐

Patient Name: ____

MATERNAL HISTORY

Age: ☐
Usual wt. ☐
Usual ht. ☐
Married ☐
Unmarried ☐

Total Pregnancies ☐
Premature ☐
Abortions ☐
Stillborn ☐
Neonatal deaths ☐
Now alive ☐

Menses:
LNMP ☐
EDC ☐
Unknown ☐

Chronic Disease:
Cardiac ☐
Anemia ☐
Renal ☐
Diabetes ☐
Thyroid ☐
Sterility ☐
Other ☐

PREGNANCY HISTORY

Prenatal Care:
None ☐
Clinic ☐
Private ☐

Drugs given:
Vitamins &/or iron ☐
Tranquilizers ☐
Diuretics ☐
Hormones ☐
Antibiotics ☐
Other ☐

Blood Type:
A ☐ Rh+ ☐
B ☐ Rh- ☐
AB ☐ Unknown ☐
O ☐
Rh titer (highest) ☐

Vaginal bleeding:
1st trimester ☐
2nd trimester ☐
3rd trimester ☐

Hydramnios ☐

Toxemia ☐

Infection:
Urinary tract ☐
Amnionitis ☐
Other ☐
Pos. serology ☐

INFANT'S FINDINGS

Clinical Diagnoses:
Resp. distress ☐
Erythroblastosis ☐
Anemia ☐
Jaundice ☐
Convulsions ☐
Asphyxia ☐
Cardiac failure ☐
Infection ☐

Rx:
Exchange tx. ☐
Antibiotics ☐
Other ☐

Pos. Bact. Cultures:
Urine ☐
Blood ☐
Spinal fluid ☐
Other ☐

Blood Type:
A ☐ Rh+ ☐
B ☐ Rh- ☐
AB ☐ Unknown ☐
O ☐

Malformation:
CNS ☐
Cardiac or pulm. ☐
G.I. ☐
G.U. ☐
Other ☐

Abnormal Laboratory:
Serology ☐
Direct Coombs ☐
hgb/PCV ☐
bilirubin ☐
glucose ☐

Autopsy:
Not requested ☐
Permission denied ☐
Obtained ☐

LABOR & DELIV. EVENTS

Labor:
Total duration (hrs) ____
Membranes ruptured:
< 6 hr. ☐
6 - < 12 hr. ☐
12- < 24 hr. ☐
24 or more hr. ☐

APGAR ☐

Resuscitation:
Intubation ☐
Other ☐

Presentation:
Vertex ☐
Breech ☐
Transverse ☐
Other ☐

Fetal distress:
Feto-pelvic dysproportion ☐
Prolapsed cord ☐
Fetal distress (meconium/FHR change) ☐

Attendant @ Deliv.:
M.D. ☐
'Midwife' ☐
R.N. ☐
Other ☐
None ☐

Placenta:
Weight ☐
Infection ☐
Sing. umb. art. ☐
Abruption/praevia ☐
Other abn. ☐

Anesthesia:
General ☐
Spinal ☐
Local ☐
Other ☐

Drugs:
Narcotics ☐
Sedatives ☐
$MgSO_4$ ☐
Antibiotics ☐
Fluids ☐
Other ☐

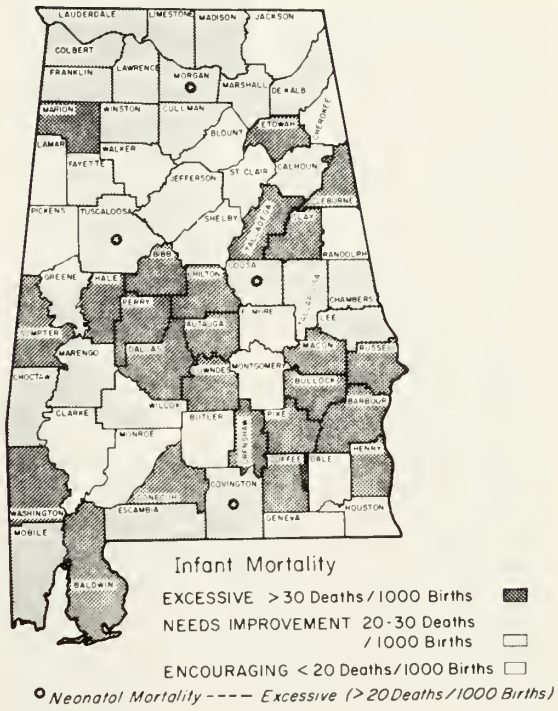
Delivery:
Vaginal ☐
Caes. section ☐
Hi forceps ☐
Low forceps ☐
Rotation ☐
Other ☐

accompanied by efforts to assure delivery of living, undamaged children.

(4) Reduction of perinatal and infant death and damage is not as expensive as our present day approach which results in accumulation and subsequent maintenance of the maimed and damaged. Preventive measures have always been less expensive than therapeutic or supportive maneuvers—prevention of those factors most often productive of infant death and disease costs pennies compared to the dollars needed for treatment, "rehabilitation" and support by society. To merely feed, clothe and put a roof over the head of a damaged child for 40 years costs someone approximately $100,000—the same amount buys a great deal of prevention.

It makes moral, medical and economic sense to launch an intensive attack on the problems of infant mortality and damage in our state. The Committee for Maternal and Infant Health of the State Medical Association, Committee for the Fetus and Newborn of the Alabama Chapter of the American Academy of Pediatrics and the Bureau of Maternal and Child Health of the Department of Public Health, State of Alabama have, therefore, endorsed a specific program designed to better improve our understanding and consequently our ability to combat this problem. Most infant mortality occurs in the first 28 days after birth (neonatal mortality) and the same factors leading to death of the live born infant also lead to death and damage prior to birth (fetal mortality). A logical start is to define and describe the scope and nature of the problem of perinatal (fetal and neonatal) mortality in this state. Toward this end, this article represents an attempt to present the seriousness of this problem in our state.

County by county infant death figures (1967) collected by the Bureau of Vital Statistics are shown in figure 1. All counties with excessive infant mortality also experienced excessive neonatal mortality and, in addition, several counties with intermediate infant death rates nevertheless experienced excessive perinatal death (indicated by



stars). In order to better understand both underlying causes and inter-county variations, more detailed knowledge is necessary concerning these deaths. Certain essential, preliminary information has been summarized in figure 2. In the future, receipt of fetal and neonatal death certificates by the Bureau of Vital Statistics will result in sending a copy of this figure to the physician concerned with the patient. Pre-coded responses, in order to provide as little "paper-work" as possible, require only a check (or X) for the appropriate answer. Brief review of the clinical details surrounding a death would appear to be a necessary and important routine practice and in-hospital review of such information by a Perinatal Mortality Committee has been urged by both the American Medical Association and the American Hospital Association (see "Neonatal Mortality," Herschel P. Bentley, Jr., Journal of the Medical Association of the State of Alabama, 36: 377-381, 1966). Details requested in this report are fundamental to proper care and should already be familiar to the responsible physician in each case. Certain questions may have more than one answer and a check of

each appropriate box will be necessary. Should further details be available, their addition is welcomed. Following completion and signing by the physician, return should be made by the usual channels for birth and death certificates to the Bureau of Vital Statistics. Information obtained will periodically be presented in this Journal and will serve as a basis for improving infant care in our state.

Committees and paper work will not begin to solve the problems of excessive infant death. Realization of the problem and acceptance of responsibility by doctors in this state is essential. Our purpose is to provide clearer definition of the problem and information necessary in order to provide realistic education for improved care to attack these problems. We invite and urgently request the talents, ideas and cooperation of all physicians in this state in the purpose of the undersigned—to reduce the tragic and unnecessary toll of infant death and damage in Alabama.

Practicing 'For Free'

Ann Landers, the syndicated columnist featured in more than 200 metropolitan dailies in the nation, answers eloquently and for all time a question that besets thousands of freshly graduated doctors every year: What about relatives, outside the immediate family, who seem surprised to get a bill for medical services from a cousin or a nephew.

". . . We just wanted to give the lad a break and help him get some practical experience," wrote a woman signing herself "Tennessee," adding: "Were we wrong?" Responded Ann caustically:

"Dear Tenn.: Just what kind of a break is it for a doctor (young or old) to make a house call at 2:00 a. m. for nix? Doctors get plenty of practical experience taking care of fathers, mothers, sisters, brothers, nieces and nephews, and grandparents for free—not to mention charity cases and clinic patients. Internship also offers a world of free experience, particularly the odd-hour variety. Pay the bill and do your cousin a favor by not giving him any more breaks in the middle of the night."



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*As shown by *in vitro* studies.
1. Crunden, A. B., Jr., and Davis, W. A.: Am. J. Obst. & Gynec. *65*:311 (Feb.) 1953.



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emesis control

BUREAU OF VITAL STATISTICS
PROVISIONAL BIRTH AND DEATH STATISTICS AND COMPARATIVE DATA
Ralph W. Roberts, M. S., Director

MAY 1968

Live Births / Deaths / Causes of Death	Number Registered During May 1968			Rates* (Annual Basis)		
	Total	White	Non-White	1968	1967	1966
Live Births	4,963	3,387	1,576	16.3	15.7	16.5
Deaths	2,546	1,729	817	8.3	9.0	9.5
Fetal Deaths	93	37	56	18.4	22.2	21.0
Infant Deaths—						
under one month	95	55	40	19.1	21.6	17.4
under one year	120	66	54	24.2	28.3	26.8
Maternal Deaths	3	2	1	5.9	4.1	7.9
Causes of Death						
Tuberculosis, 001-019	14	5	9	4.6	7.3	7.4
Syphilis, 020-029	1		1	0.3	0.7	1.0
Dysentery, 045-048						
Diphtheria, 055						
Whooping cough, 056						
Meningococcal infections, 057	2	1	1	0.7	0.7	0.3
Poliomyelitis, 080, 081						
Measles, 085					0.3	
Malignant neoplasms, 140-205	372	269	103	121.9	137.1	135.1
Diabetes mellitus, 260	39	26	13	12.8	16.8	15.7
Pellagra, 281	1	1		0.3		
Vascular lesions of central nervous system, 330-334	369	240	129	120.9	119.3	138.1
Rheumatic fever, 400-402						0.3
Diseases of the heart, 410-443	818	608	210	268.0	315.6	323.3
Hypertension with heart disease, 440-443	92	38	54	30.1	36.4	34.8
Diseases of the arteries, 450-456	48	27	21	15.7	20.2	21.1
Influenza, 480-483					1.0	3.0
Pneumonia, all forms, 490-493	70	47	23	22.9	19.5	26.7
Bronchitis, 500-502	5	4	1	1.6	0.7	2.7
Appendicitis, 550-553						2.0
Intestinal obstruction and hernia, 560, 561, 570	9	6	3	2.9	3.6	5.0
Gastro-enteritis and colitis, under 2, 571.0, 764	2		2	0.7	1.0	2.3
Cirrhosis of liver, 581	21	14	7	6.9	7.9	6.4
Diseases of pregnancy and childbirth, 640-689	3	2	1	5.9	4.1	7.9
Congenital malformations, 750-759	19	15	4	3.8	5.9	4.7
Immaturity at birth, 774-776	26	14	12	5.2	6.7	5.5
Accidents, total, 800-962	210	155	55	68.8	67.4	65.5
Motor vehicle accidents, 810-835, 960	121	95	26	39.6	30.1	31.1
All other defined causes	371	237	134	121.5	111.4	125.0
Ill-defined and unknown causes, 780-793, 795	146	58	88	47.8	48.9	53.5

*Rates: Birth and death—per 1,000 population
Infant deaths—per 1,000 live births
Fetal deaths—per 1,000 deliveries
Maternal deaths—per 10,000 deliveries
Deaths from specified causes—per 100,000 population



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New Explorations Among Life's Molecules

With a probing beam of light scientists are beginning to explore among the molecules out of which all life is woven.

By a process known as optical rotatory dispersion it is now possible to penetrate beyond the limits of visibility imposed by the electron microscope and figuratively speaking take a "look" at biology's minute building blocks—protein.

Emerging from such studies is a flicker of insight into the exquisite complexities of being alive—insight that when expanded may some day be captured in a medicine bottle for the cure of presently incurable diseases.

The importance of protein to life can hardly be overemphasized. Indeed the two, protein and life, are almost synonymous. Without one there could not be the other, as far as anyone has been able to determine. Yet knowledge about protein is sketchy. Science probably knows more about the interior of a star.

As Dan W. Urry, Ph. D., of the Institute for Biomedical Research at the American Medical Association explains it:

"We know that the individual for the most part is a unique collection of proteins. What we're trying to understand is how these proteins function—or as the case may be in disease, malfunction. We think that optical rotatory dispersion is beginning to produce some answers."

Although its use in the study of protein is a relatively recent development, optical rotatory dispersion itself is not.

Nearly a century ago the great French scientist Louis Pasteur showed that a beam of polarized light is twisted or rotated when passed through a transparent solution. Different solutions produce different twists in the light. Thus by measuring the degree of rotation Pasteur found he could get a rough analysis of an unknown substance. It's as if you could cut through a watermelon with a thin knife and determine the shape of the seeds by the way the blade is twisted.

For such work ordinary light is useless. The vibrating conglomeration of light waves in a sunbeam, for instance, are much too unmanageable for optical rotatory dispersion. But polarized light is orderly. Its waves are parallel and they travel in the same plane—like a knife edge—so that the degree by which they are rotated can be measured.

However, mere polarized light such as filters through your sun glasses is not the complete answer either. For the waves of this light, while parallel, are too big to delineate molecules. You might as well try to cast the shadow of a pin across a room with a flood lamp. In either case the light passes around the object without projecting any image or outline.

What is necessary are high-energy "ripples" of polarized light—light waves so small that they glance off molecules instead of "engulfing" them. Also there must be highly sensitive recording devices that can detect minute changes in intensity and rotation even after the light has penetrated a murky solution.

Earlier instruments for optical rotatory dispersion lacked this degree of sophistication. Then about two years ago new light sources and recorders were developed that not only can distinguish molecules, but afford a glimpse of their structure as well. It is with such instruments that Dr. Urry and a few others (among them Drs. E. R. Blout and Paul M. Doty of Harvard, and Frank Yang of the University of California) are scanning new vistas among the proteins.

Optical rotatory dispersion is not the only means of picturing protein molecules. A process known as X-ray diffraction can perform somewhat the same task. But X-ray diffraction requires that the protein first be

A science feature article prepared by the Communications Division, American Medical Association.

purified in crystal form. Optical rotatory dispersion, on the other hand, can provide a view of protein in a more life-like system—suspended in fluids similar to those of the body.

The difference, Dr. Urry feels, is important. For proteins in a living organism are not rigid molecules like lumps of concrete. Rather they are delicately sculptured mobiles capable of changing shape.

This ability on the part of protein has vast significance. For hand in hand with changes in protein structure go changes in protein function—a fact emphasized more than a decade ago by Dr. Henry Eyring of the University of Utah and Dr. Rufus Lumry of the University of Minnesota.

"Eliminate the ability of protein to change and you have very probably eliminated the possibility for life," said Dr. Urry. "For example, without changes in protein conformation blood could not effectively transport oxygen to the cells of the body; muscles could not contract and provide movement; hormones could not perform some of their regulatory functions, and antibodies could not destroy infectious disease organisms.

"Moreover, there could be little coordination of activity within the cells to produce such material as blood, hormones or antibodies in the first place—or to produce other cells, for that matter."

All such activity is carried out by a highly specialized group of proteins, called enzymes, which work under genetic control.

Enzymes are catalysts; they cause reactions to happen without reacting themselves. It is an axiom of biology that when a gene wants something done it produces an enzyme to perform the task. Thus it falls to enzymes to organize, construct, maintain and control a living organism out of about 20 chemical elements—predominantly oxygen, carbon, hydrogen and nitrogen.

Altogether a hundred thousand or so different reactions are routinely involved in human life. And it is now believed that many of these reactions depend upon the ability of enzymes to change their activity—initiating a reaction here, shutting off a reaction there.

But what causes protein to change shape and thus change activity?

So important is this question that by proposing an answer two French scientists, Jacques Monod and Francis Jacob, received the 1965 Nobel Prize in medicine.

Proteins change their shape, the Frenchmen said, by means of what they termed allosteric interactions. While the precise nature of such interactions is yet to be defined, they might be thought of as sort of "half reactions."

In a normal chemical reaction two molecules fuse to form a third molecule. For example, glucose and fructose combine to form sucrose—ordinary table sugar. In the case of allosteric interactions things don't progress nearly so far, however. There is a linking of two different molecules but no fusing into a third. What happens instead is that the molecules adjust to each other. In the process one or the other or both may be changed structurally, yet each retains its individuality.

Thus during an allosteric interaction involving a protein the shape or conformation of the protein molecule is changed by hanging another molecule on it, producing a sort of warping effect. It's somewhat like hanging wet laundry on a clothes line. The shape of the clothes line changes—stretching and bowing—but it's still the same piece of rope.

Protein conformation, however, is a good deal more complex than a clothes line. Although usually produced as a long thin strand —much like a rope—the protein molecule does not remain that way. Often it becomes spiraled corkscrew-fashion and the "corkscrew" folded and further twisted into what looks like a complicated tangle.

But contrary to appearances proteins are

not really tangles. Rather they are flawlessly tailored molecules. They have to be to carry out precise biological functions and still be capable of change.

Each type of protein has a characteristic molecular structure. And this three dimensional orientation—the manner in which the protein strand is woven about itself—in turn determines what role the molecule will play amid the complex infinitesimal happenings within a cell.

With optical rotatory dispersion and X-ray diffraction it's now possible to penetrate more directly this ravel and gain some insight into its workings.

From what has been learned it appears that in the heart of the highly-ordered protein tangle—possibly at the place where the protein strand is knotted on itself—there is an "active site." Only at this site can the molecule conduct its allotted function; perhaps mediating over an intricate reaction, perhaps linking up with other proteins to help construct a new cell.

In addition, some protein molecules have a second critical site known as the effector or allosteric site. This is the site, it seems, that provides the hand hold where another molecule can link up with the protein.

Combining this as yet meager knowledge of protein structure with the theories of Jacob and Monod, the explanation of how changes in protein conformation work changes in protein function probably goes something like this:

A molecule (perhaps another protein, perhaps some other organic chemical) binds to the effector site of the protein creating an imbalance. To compensate, the protein strand must alter its shape, and this in turn alters the active site. Thus whatever function was being performed at the active site ceases . . . or it may be that a function is initiated instead of ended.

In either event, the allosteric interaction that triggered the activity can take place only between specific molecules, for the two must fit more precisely than a key in a bank vault.

How protein achieves its all-important three-dimensional structure complete with active and effector sites is not entirely clear. But it seems that the impulse to attain a characteristic conformation is built in at the time the molecule is constructed out of subunits of amino acids.

There are about 20 different amino acids. Depending upon both the order in which these subunits are linked and the total number used, proteins of almost limitless variety can be produced. A protein molecule may contain thousands of amino acid subunits. Yet each must be in the proper place. Let just one unit be missing or misplaced and the protein may not perform as intended, or may not function at all.

Instructions for the proper alignment of amino acids into a protein molecule are transcribed in genetic code in deoxyribonucleic acid (DNA)—the stuff of which genes are made. This information, stored in the cell nucleus, is transmitted by ribonucleic acid (RNA) to ribosomes—cellular assembly points—where the protein chain is actually forged.

Even though linked together in accordance with genetic dictates, not all the amino acid subunits are content to lie docile in their bondage, however. Some have affinities for others—chemical attractions and impulses to bind together forming cross links. As a result the protein chain twists and tangles into the precise molecular conformation that will produce the results for which the gene was coded.

Once produced, however, many proteins—particularly the enzymes—seem to pass beyond direct genetic control. They are not "born free" it's true; but they do have enough leeway to respond to the molecular elements of their environment with allosteric interactions—changing shapes and in turn working other changes.

(Continued on Page 289)



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UD UNIT DOSE MEDICATION

(Continued from Page 286)

This ability to react and respond to the environment—whether it is in the environment of a cell, the body fluids or some structural tissue—is all important for the regulation and activation of life functions.

An example is the production of adenesine triphosphate (ATP). By splitting molecules of this substance the body provides itself with both electrical energy for the transmission of nerve impulses and mechanical energy to move muscles. The body of a man at hard physical labor may break down and reconstruct its weight in ATP in one day. Yet when he is leaning on a shovel less than one tenth as much ATP may be required.

Because of the vast quantities involved, ATP cannot be stored by the body. Instead it is produced as needed by certain enzymes.

But when shall ATP be produced and how much? This has to be determined by the ATP-producing enzymes, and the way they decide the matter is in response to their environment.

When energy requirements are high the enzymes are free to produce ATP at full capacity. But when less energy is used, as when a man quits working, ATP begins accumulating in the cells and tissues where it was synthesized. Some of these accumulating molecules may bind onto the effector sites of the enzymes, thus alter the active sites and switch off the enzymes' ability to manufacture ATP. Should the man resume work, the ATP is consumed, the active sites regain their functional shape and the enzymes switch back into the productive phase.

"At one time it was thought that the only way enzymes were switched off was by a jamming mechanism—the accumulation of the product they assemble at the active site," Dr. Urry said. "However, the picture we get from studies with optical rotation seems to indicate that allosteric interactions are also responsible."

Dr. Urry, in collaboration with Dr. Eyring, began his work with optical rotation by studying amino acids. Once some understanding of these basic components of proteins was obtained he teamed up with Dr. Doty at Harvard in the study of complete protein molecules.

From such studies, and from the studies of other scientists (many of who are using methods other than optical rotation) are arising new appreciation and better understanding of the basic components common to all life, whether microbes or man.

What emerges is an indication that proteins may be more than the static building blocks of life. They may contain something of the spark of life as well.

Proteins are not living molecules, Dr. Urry emphasized. But they are not inert organic molecules like lumps of coal either.

Their structure, their function, their mode of coping—after a fashion—with their environment, would appear to place protein molecules somewhere between living organisms and inanimate elements.

In pursuit of facts to test such speculations science has, in a sense, taken a tentative step beyond the strict confines of genetics. Genetics carries the web of life up to the synthesis of protein. Beyond that point the activity of many proteins, especially the enzymes, is best explained in terms of environment and allosteric interactions.

This does not mean that genes produce proteins indiscriminately; or that once produced proteins are rid of genetic influence and free to muddle about as they choose. The environment in which proteins function is still genetically dominated; and the ability of proteins to function in that environment is still genetically imparted.

The point remains, however, that close to the nub of physical being there is a unique family of molecules with some capacity for independent action. And among these busy molecules, men such as Dr. Urry are investigating with the aid of optical rotatory dispersion.

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Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral*—Adults: Mild and moderate anxiety and tension, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. Geriatric patients: 5 mg b.i.d. to q.i.d. (See Precautions.)

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References:

(1) Siver, R. H.: CMD, *21*:109, September 1954. (2) Frykman, H. H.: Minn. Med., *38*:19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., *51*:16-18, January 1955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., *15*:15-16, October 1965. (5) Weekes, D. J.: N.Y. State Jour. Med., *58*:2672-2673, August 1958. (6) Weekes, D. J.: EENT Digest, *25*:47-59, December 1963. (7) Abbott, P. L.: Jour. Oral Surg., Anes., & Hosp. Dental Serv., 310-312, July 1961. (8) Rapoport, L. and Levine, W. I.: Oral Surg., Oral Med. & Oral Path., *20*:591-593, November 1965.

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President's Page



E. L. McCafferty, Jr.

Conventions can be fun and after meeting with the Madison County doctors and members of their Auxiliary, I can promise they will make every effort to show the Medical Association of the State of Alabama a great time at the Annual Meeting in Huntsville April 24 through 26, 1969.

The enthusiasm for this meeting among the medical people, the officials at the Marshall Space Flight Center and the citizens of Huntsville itself is refreshing. They want us to come and to enjoy North Alabama. Everybody is invited and I sincerely hope that each of you will plan to make the scene.

There will be something of interest for all of you.

The scientific sessions will emphasize 21st Century Medicine, not only in a purely medical sense, but we have been invited to the Marshall Space Flight Center for an afternoon that should be interesting and rewarding for all of us who are fortunate to have this opportunity.

On Friday morning we hope to tie the whole thing together in presenting a forum on the contributions of the two disciples (Space and Medicine) working together for a better world.

The entire convention is not, however, dedicated to space and we will also have the opportunity to hear by a world authority of the tremendous advances and techniques that have been developed in cardiac transplants firsthand.

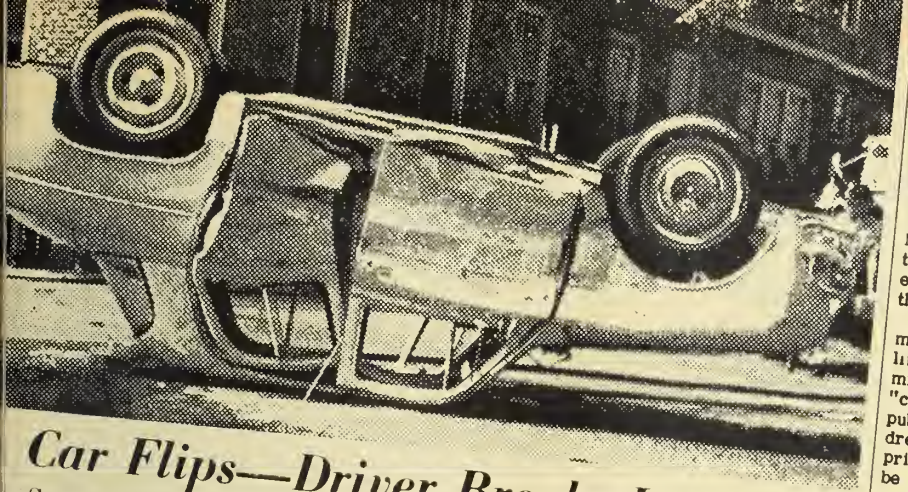
The ladies have not been forgotten and as many of you already know, there are some outstanding estates with lovely old homes in the Huntsville area. The mistresses of these homes have graciously offered to open them to our members during the meeting and a tour has been planned that all of us can enjoy.

In the past very few members and their wives have participated in the formal dances that had become almost traditional. This year it has been suggested that we try to have parties that will be fun for a greater number of our members. With this in mind a "Bierstube" is tentatively scheduled for Thursday night. This will be informal with fun as the main objective for everyone.

This isn't supposed to be the same old-type convention that many of you have become bored with, but one that will combine exciting subjects here on earth and in the sky, and if this isn't enough they even have the Tennessee river for those of you who want to touch all the bases.

The most rewarding part of any meeting, after all, is to renew your old friendships and to make new friends among your colleagues throughout the state. I hope each of you will

(Continued on Page 299)



STAFF PHOTO

Car Flips—Driver Breaks Leg

, Sept. 7. John P. Jones of incurred a broken leg today driving

Patrolman B. R. Brown, the car hit a fire hydrant and flipped over on its top. Hasn't he

statemer issue, a. tember th fications' ton dicta Althou made Mo down by a ter shar flat obje was passe Board McCredi tion" s' elimir the st. The c ment ca' limit ra mile li "cut-of public dren priv be b or th schoo The so so rather

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For the patient who has been through an accident, the worry and anxiety following the experience may actually heighten the perception of pain. This is why there's a classic ¼ grain *sedative* dose of phenobarbital in Phenaphen with Codeine—*to take the nervous "edge" off,* so the rest of the formula can control the pain more effectively.

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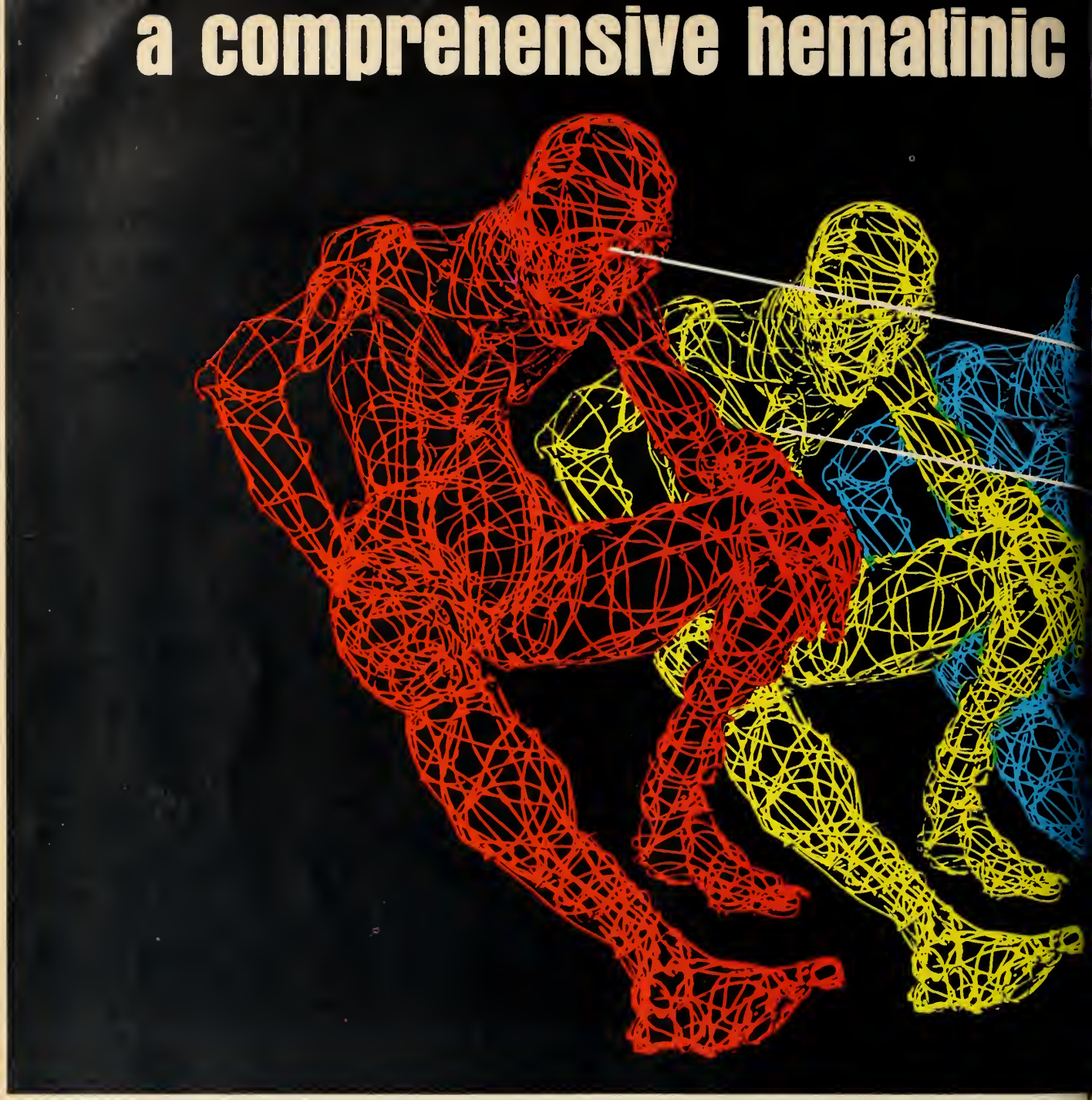
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Stuart

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(Continued from Page 294)

begin to make your plans to attend this meeting now and join with me in expressing our appreciation to the physicians, their wives, the officers at the Marshall Space Flight Center, the people of Huntsville and our honored speakers for efforts in our behalf.

I am looking forward to the pleasure of being in Huntsville in April and I hope that many of you will join me.

E. L. McCafferty Jr.

BOOKS
Of Professional Interest

THE PERSONALITY OF THE ALCOHOLIC (Guises of Dependency), by Howard T. Blane, Harper & Row, 49 East 33rd Street, New York City 10016, x plus 177 pages, indexed—$5.95.

There is a personality pattern common to the alcoholic. Man is a dependent animal, wavering between anger and depression, impulsive and frustrated, generally denying his addiction, inclined to over- or under-evaluate himself, and heavily outnumbering the female of the species.

These are the premises on which Dr. Blane builds his thesis before devoting a chapter to "The Alcoholic Woman," and then turning to the ever-present question of the normal person's attitude, of treatment and its effect, and finally of preventing alcoholism.

Dr. Blane, who is Associate Psychologist, Massachusetts General Hospital, and Assistant Clinical Professor of Psychology, Harvard Medical School, opens his introduction with the declaration that "A work about the personality of the alcoholic for the general reader has never been written." With the publication of his book, this statement no longer holds true.

—W. J. M., Jr.



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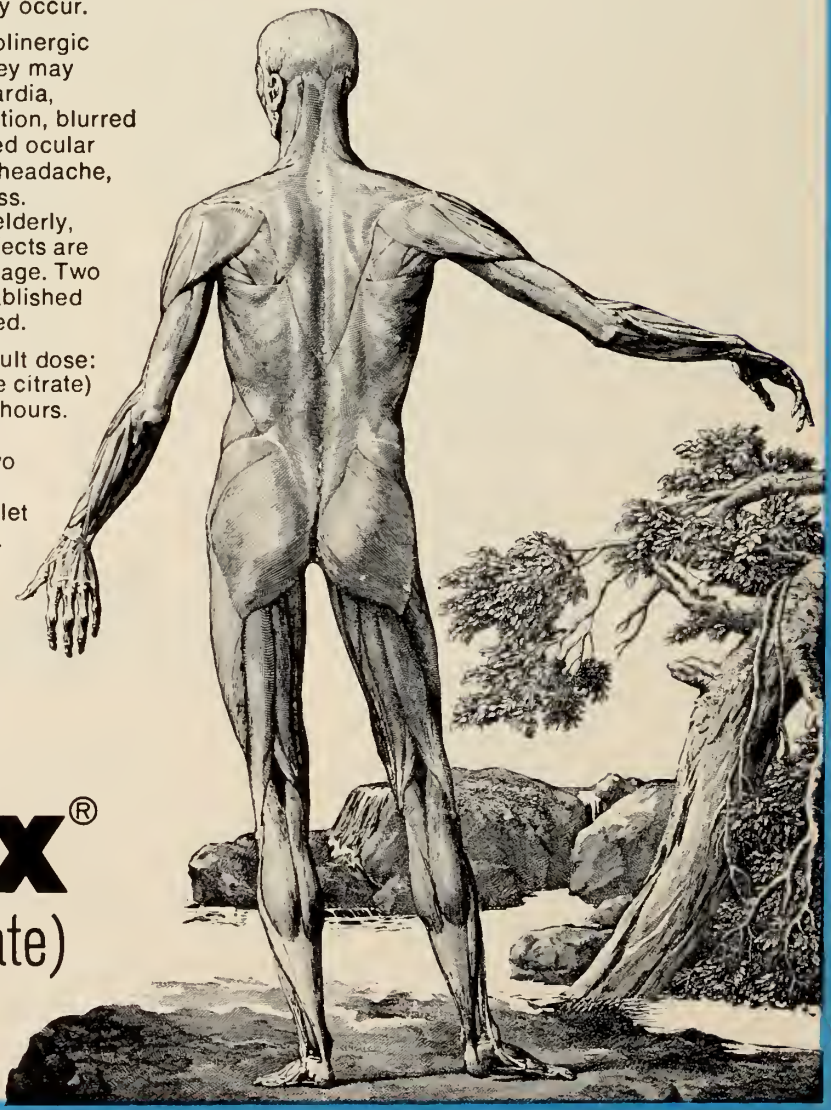
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AUXILIARY PLEDGE

"I pledge my loyalty and devotion to the Woman's Auxiliary to the American Medical Association. I will support its activities, protect its reputation and ever sustain its high ideals."

The Rural Health Conference on August 21st was an excellent meeting, and to me it was both interesting and informative. All the speakers were outstanding, and many of the present day problems were discussed intelligently, and suggestions were given as to the solution to these problems. I found "Health Manpower" by Dr. Volker especially timely, as an Auxiliary member, as well as "Smoking and Health" by Dr. Scofield and "Narcotics and Drug Control" by Dr. Myers. These are subjects which come under Mental Health in our Auxiliary work. Sen. Vacca's discussion of "Traffic Safety" was helpful as we are engaged in a Safety program. As Auxiliary members, we are concerned about Rural Health and the many problems in that particular area, and I found Dr. Washburn's address very challenging and unusual.

I have just returned from Huntsville, where I attended a meeting August 27 and 28, with Auxiliary members and Medical Association members, who are involved with plans and preparations for the State Conventions next April, which will be held in Huntsville. The local committees are busy, and have made progress with their plans. From here, it looks as though this will be an outstanding meeting for both organizations, and we are looking forward to it.

As we enter the month of September, we realize it is time to settle down to serious Auxiliary work, and many of the Auxiliaries will begin their Fall activities this month. I have been invited to several "first meetings," and will be travelling extensively throughout the month of September. I was in Oneonta on September 3rd and in Cullman on the 4th. As I go about from Auxiliary to Auxiliary in our state, I will be representing the State Auxiliary, and will be aware of the responsibilities involved. I hope that I shall be able to present the needs of the Medical Association, and the ways in which we can help most effectively, in such a way that all the local organizations will feel that they have a definite part in this important work.



Mrs. Robert K. Wilson, Sr.

Louise M. Wilson

(Mrs. Robert K. Wilson, Sr.)
President WAMASA



Editorial COMMENT

Vaccines Short As A2 'Flu Outbreak Threatens

With an outbreak of influenza A2 in Hong Kong in July tagged as having "the severest antigenic changes since 1957," and a vaccine shortage looming, doctors of the nation are being alerted and the Public Health Service was advising a limited use of available vaccine.

A supplement to the Morbidity and Mortality report states that, although strains of influenza virus from this outbreak cross-react to some extent with some previous A2 strains, they do show a marked antigenic change from previous strains. Similar viruses were subsequently isolated from an outbreak in Singapore.

The Public Health Service consequently has made a re-appraisal of the influenza prospectus for the United States and offers specific recommendations on the use of influenza vaccine.

In this connection, Dr. Ira L. Myers, state health officer, warned that with the continuous flow of military and civilians from Hong Kong, the Philippines (to where this outbreak has already spread), and from southeast Asia, an outbreak in Alabama would be quite possible in a matter of hours, particularly in a rainy period.

It is felt, says the PHS report, that the present change in the influenza virus "increases the probability that influenza A2 will occur extensively in the United States in the 1968-69 season."

Current vaccines may provide only limited protection against A2/Hong Kong/68, and better protection will require a newly formulated vaccine. Development and manufacture of it will take a considerable time, and only a limited number of doses will be available at first.

It is recommended by PHS that currently available bivalent and polyvalent influenza vaccine be given only to persons at highest risk of mortality or severe complications as a result of influenza. When monovalent vaccine becomes available the same groups should be vaccinated or revaccinated with it. High-risk groups include persons with chronic illnesses and all in the older age group.

The recommendation defined the chronically ill as "Persons of all ages who suffer from chronic debilitating diseases, including cardiovascular, pulmonary, renal, or metabolic disorders:

"1) patients with rheumatic heart disease, especially with mitral stenosis;

"2) patients with such cardiovascular disorders as arteriosclerotic heart disease and hypertension, especially showing evidence of frank or incipient cardiac insufficiency;

"3) patients with chronic bronchopulmonary diseases such as asthma, chronic bronchitis, cystic fibrosis, bronchiectasis, pulmonary fibrosis, pulmonary emphysema, or pulmonary tuberculosis."

As for older age groups, it is pointed out that during major influenza outbreaks, especially those caused by type A viruses, increased mortality has regularly been recognized for persons over 45 years of age and even more notably for those over 65. This association has been particularly marked in individuals with underlying chronic disease.

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(diphenylhydantoin)

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In untold thousands of epileptic patients... Dilantin has been, and continues to be, the bedrock of therapy.

DILANTIN is useful in the treatment of grand mal epilepsy and certain other convulsive states. Its use will prevent or greatly reduce the incidence and severity of convulsive seizures in a substantial percentage of epileptic patients, without the hypnotic and narcotizing effects of many anticonvulsant drugs.
PRECAUTIONS: Periodic examination of the blood is advisable. Nystagmus in combination with diplopia and ataxia indicates dosage should be reduced. The possibility of toxic effects during pregnancy has not been explored. ADVERSE REACTIONS: Allergic phenomena such as polyarthropathy, fever, skin eruptions, and acute generalized morbilliform eruptions with or without fever. Rarely, dermatitis goes on to exfoliation with hepatitis, and further dosage is contraindicated. Gingival hypertrophy, hirsutism, and excessive motor activity are occasionally encountered. During initial treatment, side effects may include gastric distress, nausea, weight loss, nervousness, sleeplessness, feeling of unsteadiness. Macrocytosis, megaloblastic anemia, leukopenia, granulocytopenia, thrombocytopenia, pancytopenia, agranulocytosis, and aplastic anemia have been reported. Nystagmus, lymphadenopathy, lupus erythematosus, erythema multiforme (Stevens-Johnson syndrome), and a syndrome resembling infectious mononucleosis with jaundice have occurred.
DILANTIN is supplied in several forms including Kapseals® containing 0.1 Gm. and 0.03 Gm. diphenylhydantoin sodium.
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Oil Investments— Are They Good?

Oil investments have recently been strongly recommended to physicians of Alabama through mailings of copies of letters from other physicians, suggesting that such investments are good for those in a 50% tax bracket. Several physicians have requested that this Journal seek the advice of knowledgeable men in the field of oil investing and that we report of our findings.

From our communications with physicians throughout the state, it is readily apparent that all of them have not had equally good experiences in oil speculations as those reported in letters circulated by the promoters.

Briefly stated, investigation suggests that anyone contemplating an oil investment should take one or more of several steps:

1. He should check with his accountant or the oil and gas department of his local bank. If his bank does not have an oil or gas department, they can give him information regarding the seller.

2. He should consult an independent petroleum engineer who could advise him regarding the prospects in the particular field and could review the proposal in all of its aspects.

3. He should check with the Alabama State Oil and Gas Board or the oil and gas board in the state or country in which the proposed venture is located for the development status of the field in question.

4. He should remember that although the tax burden is heavy, an oil investment offers a legal tax advantage peculiar to that industry, it is only good if the purchaser is in the higher tax brackets or if the well produces.

5. The people selling such investments usually earn 10 per cent or more on the purchase and they stand to lose nothing.

In summation, amateurs should be very wary about investing in a highly speculative venture until they have all the facts.

Medicare After Two Years

With Santa Claus season fast approaching, this seems an appropriate time to review the statistical highlights of Medicare for the period July 1, 1966-June 30, 1968.

Enrollment July 1, 1968

A. Hospital Insurance (Part A)	19.7 million
B. Supplementary Medical Insurance (Part B)	18.6 million

Hospital and Extended Care Facility Admissions and Plans For Home Health Services (July 1966-June 1968)

A. Inpatient Hospital Admissions	10.6 million
B. Extended Care Facilities Admissions	640,000
C. Start of Home Health Services	485,000

Medicare Bills Paid (July 1966-June 1968)

A. Inpatient Hospital	10.6 million
B. Outpatient Hospital	4.2 million
C. Home Health Services	1.4 million
D. Extended Care Facilities	1.3 million
E. Physicians', Independent Laboratories and Other Medical Services	45.0 million

Benefits Paid (July 1966-June 1968)

A. Hospital Insurance (Part A)	$6.3 billion
B. Supplementary Medical Insurance (Part B)	$2.1 billion

Participating Providers of Services (As of June 30, 1968)

		Beds
A.	Hospitals	6,900 (1,160,000)
B.	Home Health Agencies	2,100
C.	Extended Care Facilities	4,700 (325,000)
D.	Independent Laboratories	2,550

Needed: Medical Advice

The Alabama Safety Council, Inc. held its annual membership meeting in Birmingham the other day. Accompanying its impressive program of activities was a list of the officers and directors of the Council.

According to its program, the Alabama Safety Council is a non-profit, non-partisan, public service organization, supported by the business community in Alabama for Alabamians. Its objective is the prevention of accidents in order to reduce the injuries and economic loss they occasion.

Conspicious by its absence in any position of responsibility is the medical profession of this state. The President of the Council is plant manager of Ford Motor Co. at Sheffield; the Vice-President is president of a Birmingham insurance company; its directors are drawn from all phases of the business community ranging from banks, insurance companies, manufacturers, food distributors and petroleum operators to the professions of law and the Farm Bureau.

It seems that the advice and counsel of the physicians of this state, particularly those involved in occupational and industrial health fields, would be essential to the intelligent conclusion of the Safety Council's programs.

Malaria From Vietnam

Cases of malaria found in the Auburn-Opelika area have been isolated and brought under control, the infection traced to an outdoor movie last July, Dr. Ira L. Myers, State Health Officer, said.

The National Communicable Disease Center is keeping a complete record of "hot" cases coming from Vietnam (numbering some 3,000 a year), and the fight against the Anopheles mosquito is continuous and generally successful, Dr. Myers added.

Q. How much does the **anticostive*** **hematinic** cost?

A. No more than costive hematinics cost!

The anticostive hematinic is
PERITINIC®
Hematinic with Vitamins and Fecal Softener

A tablet-a-day provides:

● Elemental Iron (as Ferrous Fumarate)	100 mg
● Dioctyl Sodium Sulfosuccinate (to counteract constipating effect of iron)	100 mg
Vitamin B_1	7.5 mg
Vitamin B_2	7.5 mg
Vitamin B_6	7.5 mg
Vitamin B_{12}	50 mcgm
Vitamin C	200 mg
Niacinamide	30 mg
Folic Acid	0.05 mg
Pantothenic Acid	15 mg

Bottles of 60

*

anticostive, *adj.* (*anti* opposed to + *costive* causing constipation.) Against constipation. Now isn't that a good idea in an iron-containing hematinic?

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. . . And A Little Child Shall Draw Them!

Terrified children accompanied by their knowledgeable mothers may fit nicely into the atmosphere of the pediatrician's waiting rooms, surrounded by toys and other ways of diversion.

But a child with an earache, a sore throat, an infected nose or impaired vision, in a specialist's waiting rooms surrounded by adults concerned with their own ailments, can be an upsetting experience for everyone:—annoying to the grown-ups, frustrating to the medical assistants, and damaging to the image of the benevolent physician, not to mention the child and his nervous mother.

So concerned with this problem has the American Medical Association become that, according to Jim Reed of AMA, who attended the August meeting of MASA's Board of Trustees, the national association has issued a "book for children to read before going to the doctor."

Mrs. James Harvey Farrior, who frequently serves as receptionist in her husband's waiting rooms, has devised a novel way of handling the situation. Armed with coloring books and crayons, pads and pencils, she puts the little patient to creating a picture.

The result, bearing the name and age of the embryo artist, is thumb-tacked to the bulletin board on the waiting-room wall.

And each little patient, on recurring trips to the doctor's office, looks eagerly and proudly for his or her own "art" creation. Woe to Mrs. Farrior if one of these little people returns unexpectedly months later to find that particular picture crowded off the bulletin board!

"I have it right here," says the doctor's wife, taking it from a ready file. "Maybe you'd better draw me another. They have to take turns on the board, you know."



Fish, flowers, butterflies, bugs and even "Daddy" are subjects tackled with enthusiasm and confidence by little people waiting for the doctor. And 4-year-old Dana Buce has contributed more than one drawing to the bulletin board above her. Dana, daughter of the Norman D. Buces, was born at Camp LeJeune, when her father was Corporal Buce of the United States Marine Corps. She is seated here in the waiting room of Dr. James Harvey Farrior.

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Effectiveness: ACHROMYCIN Tetracycline is a crystalline broad-spectrum antibiotic which provides effective therapeutic activity against susceptible microorganisms.

Contraindication: History of hypersensitivity to tetracycline.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. Some patients may develop a photodynamic reaction to natural or artificial sunlight. Those with a history of photosensitivity reactions should avoid direct exposure to sunlight while under treatment. Discontinue drug at first evidence of skin discomfort.

Precautions: Use may result in overgrowth of nonsusceptible organisms. Constant observation is essential. If new infections appear, take appropriate measures. Use of tetracycline during teeth development may cause discoloration of teeth.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes (a case of exfoliative dermatitis has been reported); photosensitivity reaction, onycholysis and discoloration of nails (rare). Kidney—rise in BUN, apparently dose-related. Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. In young infants, bulging fontanels have been reported following full therapeutic dosage. This symptom has disappeared rapidly when drug is discontinued. Teeth—dental staining (yellow-brown) in children of mothers given tetracycline during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. Blood—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. Liver—cholestasis (rare), usually at high dosage. Tetracycline may form a stable calcium complex in bone-forming tissue. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy.

Average Adult Daily Dosage: One Gm. per day, in 4 divided doses of 250 mg. each. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

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TETRACYCLINE

Actually ACHROMYCIN works wherever the infection is due to an organism your lab cultures have shown to be tetracycline-sensitive. No other tetracycline—or analogue—can assure you of quicker or more effective antibiotic action. After all, isn't that what you want for your patient?

ACHROMYCIN was a pioneer in tetracycline therapy. Seventeen years of experience have shown that when the respiratory system, the genitourinary system, or the skin and soft tissue require treatment for infection probably caused by any of a number of sensitive strains, ACHROMYCIN is a wise choice for therapy while awaiting test results.

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The Month in Washington

From the Washington Office
American Medical Association

Washington, D. C.—President Johnson signed into law the Health Manpower Act of 1968 which extends for two years, until June 30, 1971, and expands the federal programs of aid to medical and allied health schools.

Other health legislation enacted into law: 1) establishes a National Eye Institute as part of the National Institutes of Health; 2) requires federal buildings to provide easy access to the handicapped; 3) authorizes standards to prevent gas lines from leaking and exploding.

President Johnson termed the health manpower law "a major measure in the battle for better health." It authorizes about $1.2 billion in federal aid to medical and other health personnel schools over two years for construction, expansion and operating expenses. Congress followed most of the Administration's proposals in approving the legislation but limited the extension to two years, instead of the four years requested.

Schools of pharmacy and veterinary medicine were made eligible for the first time.

Money authorizations for schools in the new law:

Medical and other health professions—construction grants, $395 million; institutional support, $285 million; scholarships, $32.8 million; student loans, $70 million; total, $782.8 million.

Nursing—construction, $60 million; institutional support, $75 million; traineeships, $34 million, scholarships, $50 million; student loans, $41 million; total, $260 million.

Allied health (fiscal 1970 only)—construction, $10 million; institutional support, $20 million; traineeships, $5 million; new methods, $4.5 million; total, $39.5 million.

Public health—graduate training, $20.5 million; traineeships, $24 million; total, $44.5 million.

Health research construction, $50 million.

* * *

Both the Democratic and Republican 1968 national campaign platforms cited the importance of the role of private enterprise in the development of government health programs. The GOP placed greater emphasis on private medicine than the Democratic party did.

"While believing no American should be denied adequate medical treatment, we will be diligent in protecting the traditional patient-doctor relationship and the integrity of the medical practitioner," the Republican plank said.

The Republican platform also pledged "to encourage the broadening of private health insurance plans," including extension to cover mental illness.

"Through a partnership of government and private enterprise, we must develop new coordinated approaches to stem the rise in medical costs without lowering the quality or availability of medicare care," the Democratic platform said.

Without being specific, the Democrats indicated support for universal government health insurance or, at the least, wide expansion of medicare or medicaid (or both). Boasting of "giant steps" in the past eight years "in assuring life and health for its citizens," their platform said: "We Democrats are determined to take those final steps that are necessary to make certain that every

(Continued on Page 314)

She's come down to stay

You're unlikely to see her blood pressure escape control after a few weeks or months. Because tolerance is rare with guanethidine—and Esimil is guanethidine tempered with hydrochlorothiazide.

Addition of hydrochlorothiazide makes guanethidine easier to handle, hypertension easier to control.

With Esimil, doses of components are smaller than would be necessary if either component were used alone. Side effects are often minimized. And, dosage is easy and convenient—usually just one or two tablets once a day.

Consider Esimil whenever milder agents fail to give the degree of blood pressure control you desire.

When you get the pressure down with Esimil, it usually stays down!

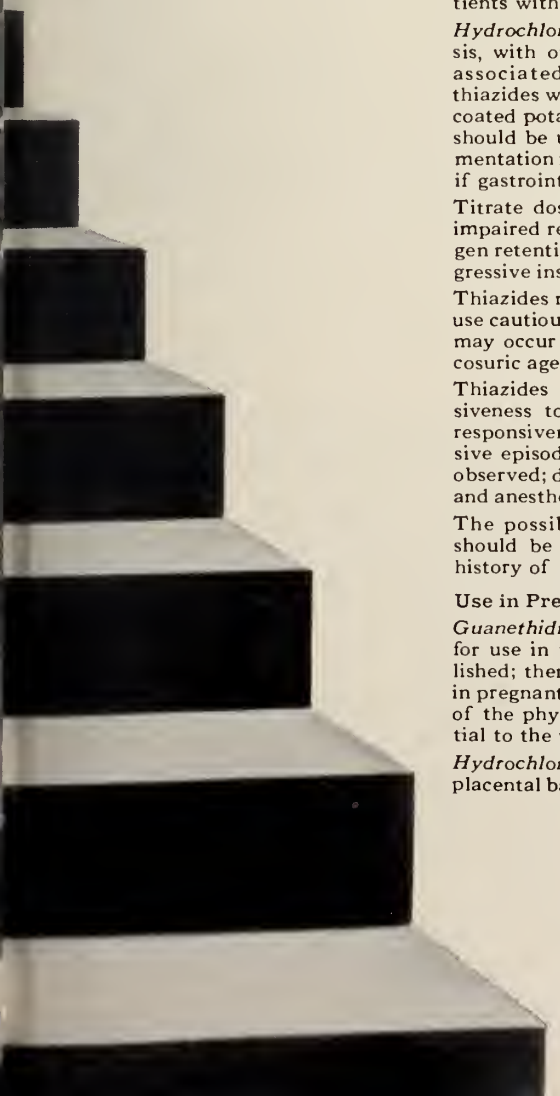


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the antihypertensive of tempered potency

Esimil®

guanethidine monosulfate 10 mg
hydrochlorothiazide 25 mg



INDICATIONS

Hypertension which cannot be adequately controlled with simpler agents; moderate to severe hypertension; sustained hypertension; almost all forms of fixed and progressive hypertensive disease; when side effects of other antihypertensives prevent effective treatment.

CONTRAINDICATIONS

Guanethidine: Proven or suspected pheochromocytoma; hypersensitivity to guanethidine. Do not use with MAO inhibitors.

Hydrochlorothiazide: Anuria; progressive renal or hepatic disease; allergy to thiazides or other sulfonamide-derived drugs.

WARNINGS

Guanethidine: Orthostatic hypotension may occur early in treatment, on arising, during hot weather, and after alcohol, prolonged standing, or exercise. Caution patient to sit or lie down with the onset of weakness or dizziness.

Concurrent use with rauwolfia derivatives may cause bradycardia, mental depression, and postural hypotension.

Withdraw therapy 2 weeks prior to surgery if possible to reduce hazard of cardiac arrest or arrhythmia. If not, administer preanesthetic agents, anesthetics, and vasopressors cautiously in reduced dosage with oxygen and atropine ready for immediate use.

Febrile illness may reduce dosage requirements.

Due to catecholamine depletion and increased responsiveness to norepinephrine, special care is required when treating patients with a history of bronchial asthma.

Hydrochlorothiazide: Small bowel stenosis, with or without ulceration, has been associated with use of enteric-coated thiazides with potassium, and with enteric-coated potassium alone. Coated potassium should be used only when dietary supplementation is not practical and discontinued if gastrointestinal symptoms arise.

Titrate dosage carefully in patients with impaired renal or hepatic function or nitrogen retention; discontinue thiazides if progressive insufficiency is observed.

Thiazides may decrease glucose tolerance; use cautiously in diabetics. Hyperuricemia may occur but is readily reversed by uricosuric agents.

Thiazides may decrease arterial responsiveness to norepinephrine and increase responsiveness to tubocurarine. Hypotensive episodes under anesthesia have been observed; decrease dosage of preanesthetic and anesthetic agents.

The possibility of sensitivity reactions should be considered in patients with a history of allergy or bronchial asthma.

Use in Pregnancy

Guanethidine: The safety of guanethidine for use in pregnancy has not been established; therefore, this drug should be used in pregnant patients when, in the judgment of the physician, its use is deemed essential to the welfare of the patient.

Hydrochlorothiazide: Thiazides cross the placental barrier and appear in breast milk. Thus, adverse reactions seen in the adult may occur in the newborn.

PRECAUTIONS

Guanethidine: Give cautiously to patients with severe coronary insufficiency, recent myocardial infarction, or cerebrovascular insufficiency and with extreme caution in those with severe congestive failure. Peptic ulcers and some other chronic disorders may be aggravated by guanethidine.

Appetite suppressants (amphetamines) and mild stimulants (*eg,* ephedrine, methylphenidate) may decrease the hypotensive effect of guanethidine.

Wait one week after discontinuing MAO inhibitors before starting guanethidine.

Periodic blood counts and liver function tests are advised during prolonged therapy.

Hydrochlorothiazide: Monitor indicated blood chemistry and fluid and electrolyte balance carefully in patients on thiazide therapy, especially when patient is vomiting, receiving parenteral fluids, steroids, or digitalis. Supplemental potassium and nonrigid salt intake will help prevent hyponatremia, hypochloremic alkalosis, and hypokalemia.

ADVERSE REACTIONS

Guanethidine: Dizziness, weakness, lassitude, syncope, bradycardia, increase in bowel movements, diarrhea, inhibition of ejaculation, fluid retention, edema, congestive heart failure. Less frequently: dyspnea, fatigue, nausea, vomiting, nocturia, urinary incontinence, dermatitis, scalp hair loss, dry mouth, rise in BUN, ptosis of the lids, blurring of vision, parotid tenderness, myalgia, muscle tremor, mental depression, chest pains (angina), chest paresthesias, nasal congestion, weight gain, and asthma in susceptible individuals.

Hydrochlorothiazide: Anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic), pancreatitis, hyperglycemia, glycosuria, muscle spasm, weakness, restlessness, dizziness, vertigo, paresthesias, headache, xanthopsia, purpura, photosensitivity, rash, urticaria, necrotizing angiitis, leukopenia, thrombocytopenia, agranulocytosis, aplastic anemia. Orthostatic hypotension may occur and may be potentiated by alcohol, barbiturates, or narcotics. Whenever adverse reactions are moderate or severe, reduce dosage or withdraw therapy.

DOSAGE

Optimal dosage must be determined for each individual. *Note:* 10 mg guanethidine monosulfate present in Esimil is equivalent to 8.4 mg guanethidine sulfate USP (Ismelin®).

SUPPLIED

Tablets (white, scored), each containing 10 mg guanethidine monosulfate and 25 mg hydrochlorothiazide; bottles of 100.

Before starting therapy, consult complete product literature.

CIBA Pharmaceutical Company
Summit, New Jersey 2/3716-R1

(Continued from Page 311)

American, regardless of economic status, shall live out his years without fear of the high costs of sickness."

The Democratic health plank also said medical costs could be lowered by more out-of-hospital care, comprehensive group practice arrangements, increased availability of neighborhood health centers, and the greater use of sub-professional aides.

The Republican platform said "inflation produced by the Johnson-Humphrey Administration" was a major factor in the increases in health care costs.

American Medical Association spokesmen appeared before the platform committees of both parties at pre-convention hearings. Dr. Donald E. Wood, Indianapolis, Ind., chairman of the AMA's Council on Legislative Activities, testified at the Republican hearing; Dr. John R. Kernodle, Burlington, N. C., a member of the AMA Board of Trustees, at the Democratic. Their statements were the same.

The AMA statement erpressed hope that the next federal Administration, whether it be Democratic or Republican, "will provide men and women in medicine, and those engaged in the allied sciences, the opportunity to think and work in a free atmosphere to pursue their common goal of a better and more healthful life for everyone."

The AMA emphasized the desirability of health programs being partnerships among private enterprise and federal, state and local governments. The AMA pledged its support to such cooperative programs for mental illness, infant mortality, occupational health and safety, and education of physicians and allied health personnel.

Concerning health care costs, the AMA said:

"We believe that programs to increase the production of medical and other health personnel can be cooperatively and effectively undertaken. We are further firmly convinced that we can and must work toward a health in the inflationary spiral, and toward a productive use of tax dollars expended in the health area. New and old tax supported programs in the health field should be critically evaluated so that while the best health care is attained, overlapping, waste and unnecessary programming are avoided. In this regard, we recommend the establishment of a cabinet-level Department of Health, headed by a physician as Secretary, with overall responsibility for all federal health programs, so that maximum effectiveness may be attained.

"We have always maintained that high-quality medical care should be available for all Americans, including those who need assistance in meeting the costs of such care . . . Firmly convinced that adequate health insurance coverage is the choice mechanism for the financing of quality health care costs, we suggest that the country embark on a program of tax credits for health insurance premiums. Under such a plan, all individuals and families would be encouraged to provide themselves with health care cost protection, with those in financial need receiving the greater amount of tax credit on a graduated basis."

* * *

The Food and Drug Administration and the Pharmaceutical Manufacturers Association differed as to the significance of the findings of a Georgetown University School of Medicineman team after studies comparing three brand-name drugs with their generic versions.

Drugs tested were diphenylhydantoin, prescribed for treatment of epilepsy, chloramphenicol and sulfisoxazole. The studies supported by the FDA showed:

1. Some generic drugs are absorbed more slowly by the body than the brand;

2. At least one generic drug was absorbed

faster by the body than the brand drug;

3. Absorption rates were governed by such factors as crystal size of the drug, hardness of tablets, and the types of drug capsules.

"Our findings raise serious doubts about the equality of different products of the same drug in the treatment of disease," said Christopher M. Martin, M. D., Professor of Medicine and Pharmacology.

"The studies by Dr. Martin and his research team, showing how different versions of the same drug behave differently in man, provide further proof of the scientific fact that these differences can be significant in patients," C. Joseph Stetler, PMA President said.

"Clearly, there is no evidence to indicate that all formulations of the same drug are equivalent. From all the evidence that has been developed to date, as Dr. Martin's studies point out, quite the opposite may be true."

On the other hand, FDA Commissioner Herbert Ley, Jr., M. D., said his agency "has in no sense concluded that 'generic' drugs are less effective as a class than 'brand-name' products."

"In my opinion, there are fewer than two dozen drugs where therapeutic differences among competing products may be a problem," he said.

"Data from the Georgetown work have been useful to the FDA, but it is completely unwarranted to reach any general conclusions about drug equivalency on the basis of these exploratory studies."

* * *

A retired air force officer, Maj. Gen. Theodore C. Bedwell, Jr., M. D., 59, has been appointed to the newly-established post of chief medical officer for the medicare program. He will be liaison with the medical profession.

He most recently was director of staff, office of the deputy assistant secretary of defense (manpower—health and medical). A native of Texas, he was graduated from Baylor University Medical College. A holder of the distinguished service medal, Dr. Bedwell in 1962 received the American Medical Association's special aerospace medicine honor citation.

Myths About Safety Belts

Despite the proven value of safety belts in reducing injury and in saving an estimated 8,000 to 10,000 lives every year on our highways, myths about the **dangers** still persist.

One such myth which expresses a fear that seat belts cause severe abdominal injuries should be laid to rest permanently by findings of a new study made by the Automotive Crash Injury Research Project of Cornell Aeronautical Laboratory. The study showed that a significant risk of injury rarely exists from seat belts, except in accidents in which the individual would almost certainly be severely injured or killed if he were not wearing a seat belt.

Abdominal injuries occurred in five per cent of the accidents studied, but 90 per cent of those injuries were minor and superficial. In fact, only one half of one per cent of those injuries were severe and, undoubtedly, most of those injuries would have been listed under the fatalities column if it were not for the fact that the injured person was wearing a seat belt.

Another myth concerns the fear of being trapped by a seat belt in a burning or submerged automobile. Actually, the belt improves the occupant's chances of remaining conscious and extricating himself from the vehicle. Furthermore, less than one per cent of all automobile accidents involve fire or submersion.

The American Academy of Clinical Toxicology

The American Academy of Clinical Toxicology has been founded for the advancement of clinical toxicology, a medical specialty concerned with the diagnosis and treatment of poisoning and drug intoxication.

The purposes of the Academy are to encourage clinical investigation, to promote the development of diagnostic and therapeutic methods, to foster among practicing physicians a better understanding of the treatment of poisoning, and to improve the medical care received by the poisoned patient.

Five catagories of membership are provided. *Fellowship:* Fellows are physicians in the full time practice of clinical toxicology with five years experience and who have been judged by the Examining Committee to have fulfilled the requirements set forth by the Constitution and By-laws. *Active Members:* Physicians who are called upon to provide clinical care for the poisoned patient as part of their practice. *Associate Members:* Physicians with no direct involvement in patient care and other scientists whose activities contribute to the advancement of clinical toxicology. *Honorary:* Honorary membership may be voted non-members in recognition of distinguished service or contributions to the objectives of the Academy. *Sustaining Members:* Sustaining membership is provided for organizations wishing to contribute additional financial support to the Academy as an aid in the achievement of its objectives.

The Academy will provide its members with a suitable periodical for the publication of original contributions to clinical toxicology. In addition to an annual business meeting and scientific program, the Academy will sponsor a symposium on some aspect of the practice of clinical toxicology with the proceedings to be distributed to the membership. Ad Hoc committees will be appointed by the Academy to prepare special reports intended to assist the physician toward better utilization of available resources. Subjects under consideration are: Emergency room facilities, ER and I. C. U. nursing, Rapid analytical procedures, Documentation and reporting of toxic reactions, etc. . . *Clinical Guidelines* in the treatment of poisoning will be a series of brief discussions limited to individual toxic substances presenting pertinant data required for clinical management. The Academy will maintain a register of consulting clinical toxicologist by geographic area to whom physicians calling for assistance may be referred.

An active program of continuing education will be pursued by the Academy to provide the physician in practice with opportunity for specialized training in the management of poisoning. The Academy will sponsor annually a 2 to 3 day intensive training program on the treatment of poisoning. The Academy will participate with regional and local medical groups in the presentation of one day training programs by provision of teaching aids and assistance in the location of suitable faculty.

An organizational meeting of the American Academy of Clinical Toxicology is planned for October 22, 1968, 9:00 a. m. to 12:00 a. m.. Drake Hotel, Chicago, Illinois. Applications for charter membership and further information may be obtained from: Eric G. Comstock, M. D., Acting Secretary-Treasurer, American Academy of Clinical Toxicology, P. O. Box 2565, Houston, Texas 77001.

Calendar of Annual Meetings

Medical Association of the State of Alabama

1969, April 24-26, Carriage Inn, Huntsville

1970, April 30-May 2, Mobile

1971, April 22-24, Birmingham

1972, April 20-22, Montgomery

1973, April 18-21, Mobile

Pensacola Cardiologist, Internist Heads ARMP After January 1st

A Pensacola doctor, prominent in the field of cardiology, who played a leading part in a highly praised cooperative internship and residency program for the three Community hospitals in Pensacola, will become director of the Alabama Regional Medical Program on January 1, 1969.

In addition, he has been appointed Professor of Medicine (Cardiology) of the Medical College of Alabama.

Announcement of the choice of Dr. John M. Packard and his acceptance was made by the Medical Center of the University of Alabama in Birmingham, in a statement by Dr. Benjamin Wells, Program coordinator of the ARMP, and Dr. S. Richardson Hill, Jr., dean of the Medical College of Alabama.

Dr. Packard will have charge of all medical and professional aspects of projects to be developed under ARMP.

The Pensacola program won national acclaim for its striking success as a community-based project for graduate education, Dr. Wells reports, and Dr. Hill adds: "The Alabama Regional Medical Program is extremely fortunate to secure the services and leadership of a physician who is strongly identified with excellence in the practice of medicine and with continuing education at the community level."

Until the appointment is effective Jan. 1, Dr. Packard will be available for consultations in Birmingham and elsewhere in the state.

Dr. Packard received his B.A. degree from Yale University 1942. After receiving his medical degree from the Harvard Medical School in 1945, Dr. Packard completed an internship at Presbyterian Hospital in New York City and a medical residency at Peter Bent Brigham Hospital, Boston.



Dr. John M. Packard

The following eight years he was with the U. S. Navy, and, at the time of his discharge, was Flight Surgeon to the Carrier Air Group Seven, Pensacola, Fla. Dr. Packard has been engaged in specialty practice in internal medicine and cardiology in Pensacola for 22 years. He has served on the active and consulting staffs of several local hospitals.

Dr. Packard is a Diplomate of both the American Board of Internal Medicine and the National Board of Medical Examiners, and is a Fellow of the American College of Physicians and the American College of Cardiology. The new director, who holds memberships in numerous professional organizations, is a former president of the West Florida Heart Association and the Florida Society of Internal Medicine.

Health Of People Concern Of Medical World

The most frequent question I have been asked since becoming President of the Medical Association of the State of Alabama is how do you have time to practice and also serve as President. The answer is quite simple, Medical Assistants. I want to pay tribute tonight to the staff at our State Headquarters for the outstanding job that they have done since Mr. Patterson's illness in the middle of June. The level of excellence with which they have performed their duties is the best example of knowledge, devotion, and loyalty that I know. And since these are the qualities that your association is promoting among its members, we as a state association and on a national level are happy to be a part of your program. And I hope we can over the years continue to participate with you in your efforts to achieve these goals.

It is indeed an honor to be back with you tonight on the occasion of your Seventh Annual Seminar . . . When I recall that it was only 90 days since I had the honor of addressing your annual convention at Mobile, I am flattered all the more that you would invite me again so soon . . . Perhaps this is the best proof we need that our Medical Assistants are long-suffering young women whose sacrifices to their profession know no limits.

Last year was the First Seminar of the Alabama Association of Medical Assistants which our Association had the privilege of sponsoring . . . Prior to last year you conducted your Seminar under the auspices of the University of Alabama School of Commerce. This indicates to me that you have advanced your interest beyond the range of secretary and bookkeeper and now are concerned with more of the strictly medical aspects of your duties.

Those of us who have watched with great interest and pride your development into a professional status all your own feel confident that each year your Seminars will delve into new and uncharted areas of health care.

I am extremely happy to see that the theme of this year's Seminar revolves largely around those subjects which have fascinated me most during the span of my participation in organized medicine.

As an example, I noticed that tomorrow morning your program will consist of two main subjects which I wish every person connected with the provision of health services in Alabama could attend . . . Your first session tomorrow morning will consist of a panel discussion "Creating An Image" . . . The moderator will be Mr. Tom Johnson, Editor, of the Montgomery Independent Newspaper, who has won a reputation, so I am told, as being a hard-hitting, plain spoken editor who believes in biblical pronouncement: "Ye shall know the truth and the truth shall make you free" . . . Mr. Johnson's newspaper is not the largest in Alabama by any means, but there are many who believe it ranks among the best . . . His job, I believe, is to puncture the balloons of our complacence and to rub raw our attitudes of indifference or neglect which so often have created a barrier of misunderstanding between the physician, the members of his staff and the patient and his family . . . If Mr. Johnson comes before you tomorrow morning and tells you just the things you want to hear, heaps praise upon your shoulders and fills your head or ears with compliments, then he will not have benefited us one whit . . . On the other hand, if he goads us sufficiently to make us realize those of our shortcomings which erode the pleasant relationship between the sick people and that corps of men and women who are dedicated to their serv-

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(Text of the speech of Dr. E. L. McCafferty, Jr., president, Medical Association of the State of Alabama, before the seventh annual Seminar of the Alabama Medical Assistants Association, in Montgomery Saturday, August 3rd)

ice, then this can be the most valuable 45 minutes you will spend all year.

I am also delighted to know that tomorrow morning's session has 45 minutes assigned for a discussion on Legislation by Miss Nina Miglionico, a member of the City Council of Birmingham . . . Before your next Seminar is held, I would remind you that a new Congress will have been sworn in in Washington, D. C., and the Alabama Legislature will have been in session for almost half a year.

Thousands of bills relating to the health provisions and the care of sick people will have been introduced in Washington, in Montgomery, and in all the other state capitols where legislators will be meeting this year.

It is a matter of great concern to me that so many citizens of this country have failed to realize the importance of their active participation in the affairs of Government . . . In a democracy such as ours, the most powerful man is he who goes to the polls on election day and casts his ballot for the candidate of his choice. Good citizenship demands this as the very minimum . . . More valuable is the man or the woman who exerts even greater effort toward the achievement of good government by first informing herself of the crucial issues of the day and second, determining to her own satisfaction whether the person seeking office has the stamp upon him of a statesman or a charlatan.

It may interest you to know that before assuming the office of President of this Association I had the privilege of serving for many years as a member and Chairman of the Committee on Legislation of our Association . . . In this position I was constantly amazed by the number of bills which have a direct and permanent effect on health care which were introduced each year in the State Legislature and the National Congress.

The majority of these bills came, not from the professional or voluntary health organizations, but from every conceivable direction . . . Most of them were based on emotion generated by some bleeding heart individual or organization and bore absolutely no real relation to the needs of the people.

I am proud to say that in my years of service as a member of the Committee on Legislation that the group which I represented never introduced, supported, or fought for a bill which would have put one cent into a doctor's pocket—directly or indirectly, nor eased his lot in life in the slightest . . . Our interest ranged from abortion and animal research to workman's compensation and X-ray, but always we were concerned with the health of the people . . . The bills which we supported—often times as they were written, sometimes with amendments proposed by us—were designed to deliver the best possible health care to the largest number of people at the lowest possible cost.

Long before the federal government became concerned with providing comprehensive health care for the poor people of this nation, the medical profession, individually and collectively, were rendering this service freely and voluntarily without cost to the taxpayers . . . We consider this as one of our obligations to society and we were prepared to continue this service into all future time.

Unfortunately, health care for the indigent, the blind and the disabled became a political issue . . . It was seized upon by selfish, self-seeking and unscrupulous persons who knew nothing of the medical needs of our population and cared less about the bankruptic cost which unlimited physicians and hospital services could result.

The medical profession and all those connected with it—and this includes you ladies tonight who very definitely are an integral part of our profession, has been buffeted and slandered in recent years because the Medicare and Medicaid programs, the Heart Disease-Cancer-Stroke Program, the Military Dependents Health Programs, Headstart, the OEO Poverty Program, the Appalachian Pro-

(Continued on Page 322)

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CONTRAINDICATIONS: Not recommended during pregnancy.

WARNINGS: May be habit-forming. Do not use in patients sensitive to barbiturates or in those with moderate to severe hepatic disease.

ADVERSE REACTIONS: Nausea, transitory dizziness, rash. Overdosage of allobarbital produces symptoms typical of acute barbiturate excess.

DOSAGE: Adults: 1 or 2 tablets every 4 hours. Not to exceed 8 tablets in 24 hours. Children 6 to 12: 1/2 to 1 tablet every 4 hours. Not to exceed 4 tablets in 24 hours.

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(Continued from Page 319)

gram for Health and Rehabilitation, the Maternal and Child Health Programs including prenatal and postnatal facilities, the Crippled Children's Rehabilitation Program and others too numerous to list here have been taken out of the hands of the volunteer agencies which once provided these services as labors of love and civic duties . . . These responsibilities have now been delivered into the hands of the government bureauracies at the federal, the state and the local levels.

When the Medicare-Medicaid law was passed, the physicians and hospital administrators of this nation were called into convention by the federal agencies and told: "We want first class care for the beneficiaries of these new programs. We want these patients to have everything which the richest people in this country are now receiving; and the federal government will foot the bill."

What did this mean? . . . This meant hospitalization for people who had never been inside a hospital before . . . This meant an unlimited supply of drugs, physical therapy and all the other services which they had never received . . . This meant the expenditure for construction and operation of hundreds of extended care facilities (nursing homes) throughout the country.

America was faced with a critical shortage of doctors, nurses, hospital beds, technicians and other health personnel because suddenly upon their shoulders was heaped the additional responsibilities of thousands of welfare patients demanding and receiving services which were unheard of just the year before.

Of course, the total cost of health care sky-rocketed . . . What else could one expect when the patient load was doubled and no limitation was placed on the amount of services to be rendered each patient . . . Personally, I seriously doubt that the quantity of health services rendered by physicians is much greater today that it was in 1958 for those who truly need medical care. I submit that the increased cost is caused by the fact that the bill for treating these patients is being made for the first time a part of the public record and no longer is the physician writing off a large part of it as a free service or service rendered at reduced prices.

Now the very politicians who campaign for office on "pie in the sky" platforms of free health care for everybody have learned for the first time what the services actually cost and they are looking for a scapegoat . . . They are blaming the doctors, the hospitals and the nurses, and the nursing homes and the drug stores for a situation which they created and for which, in the end, they alone must bear the responsibility.

You and I know that there are not enough doctors, or nurses, or hospitals or other health personnel in Alabama to render unlimited health services to every person in this State . . . Why, if every citizen of Alabama just came in to a doctor's office once a year for an annual physical examination, the strain upon the medical profession would be intolerable . . . If every expectant mother received full and complete prenatal and postnatal care; if every baby received pediatric services; if every person needed major or minor surgery could receive it, the strain upon our health facilities would crush them before the end of the year.

Desirable as it would be, I must place myself squarely beside Dr. Milford O. Rouse, Immediate Past-President of the American Medical Association, when he took the realistic position that health care is not a right of the people but it is something for which we should ever strive keeping always in mind that there are limits to what any nation can do in a democratic society under the free enterprise system.

The alternative to what we are doing today is the complete and total regimentation of the medical and paramedical professions of this nation. If every person is to have unlimited health care, hospitalization, drugs, and all of the other services, then the Con-

gress must enact a medical draft act of the same scope which this nation now employs to keep its military ranks filled . . . This nation must establish medical schools to train physicians, nurses, technicians and other members of the health team to the same extent it trains soldiers, sailors and airmen . . . The millions of dollars which now are appropriated for construction of health institutions must be trebled or quadrupled without delay for there just aren't enough facilities available today to fulfill the promises of health care which the politicians have made.

Those who would make whipping boys of the health team have failed to take into consideration that the cost of living is constantly increasing and that the fee which a doctor charges for an office visit must be divided with his medical assistant, nurses and laboratory technicians . . . Good medical care today requires diagnostic procedures and equipment which were unheard of 25 years ago . . . The health team—the doctors, and all of his professional assistants—must keep abreast of the latest techniques just as you ladies are doing this weekend . . . This means time away from the care of patients, both yours and mine, when we seek to improve our abilities to render better care to those patients.

Yes we are concerned today with legislation, just as we are concerned with public relations . . . It appears that these subjects have become so correlated as to mean one and the same thing . . . Our public relations probably is the most important problem we face today and let us all remember that it begins with the patient when he enters the front door of our offices or our institu-

(Continued on Page 324)



THE BRADLEY CENTER

An all new homelike psychiatric residence located on a lovely five-acre tract inside the city, providing a comprehensive range of services, including inpatient (28 beds), day care, and outpatient treatment. The therapeutic setting is an open community one with no provisions for locked wards. Each patient participates in an intensive treatment program consisting of individual pyschotherapy, group psychotherapy, topical small group discussions, occupational therapy and recreational therapy, and other group activities in the Center as well as in the community, depending on individual interests and needs. Drugs are used when appropriate.

Any individual may be admitted who, in the opinion of the staff, might benefit from the services provided in this particular setting. This can best be determined by a preadmission consultation with the person and a responsible member of his family.

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(Continued from Page 323)

tions . . . It is this patient—already sick and worried and not his normal self who carries away with him from our offices the opinions which later impel the politician to seek legislation to correct conditions which may exist only in the mind of a disgruntled patient.

We all know that many complaints voiced by patients are true. Doctors and medical assistants and nurses are human and prone to make mistakes. Often they are burdened with personal problems which prevents them from realizing at the moment that the patient is a unique individual—not his normal self and must receive a degree of compassion and sympathy which he would not ordinarily demand . . . Granted that many of our legislative and public relations problems could have been averted had we been more attentive in past years to establishing a perfect physician-patient relationship . . . This is now de facto but fortunately time remains to correct the situation to a large extent provided we can identify our problems with an accuracy approaching the scientific and take immediate steps to correct them.

It is generally conceded that the individual physician, in most instances still enjoys the love and confidence of his patient. It is when organized medicine is considered collectively that the public image begins to tarnish.

In the time remaining in my administration I am dedicated to working with the physicians of Alabama toward the goal of improving our public relations image using whatever methods are deemed necessary. I expect to travel the length and breadth of this state proclaiming the necessity for each physician to reevaluate the relationship of himself and his staff to their patients toward the end that a new and congenial understanding can be developed.

As I said in the beginning, the individual citizen of Alabama through his power as a voter is the strongest influence on legislation in this state. We can, and we must win these masses to our viewpoints . . . We can and we must convince the people of Alabama—each of us working within the narrow confines of our medical practices, that the health team desires only to serve them to the best of its ability; to relieve their suffering; to make them well again; to protect them from disease and injury by making our powerful influences count wherever mankind dwells or travels.

The range of our interests should know no bounds . . . Our influence must be felt in the home, on the highways, in the industrial plants, along the waterways and in the air . . . We must cling to the conviction that whatever makes Alabama citizens healthy, makes Alabama strong and prosperous and a happy place for all of us.

I thank you.



AMA Convention Streamlined For Busy Doctor

At no time in medical history has there been such an explosion of scientific knowledge and technology. And never has there been a greater demand for physicians' services.

These factors combine to burden the busy physician in his efforts to keep abreast of the modern developments in medicine.

There is an abundance of fine scientific publications, but many hours of reading would be required to learn what can be gained by attending the Clinical Convention of the American Medical Association. It will be in Miami Beach, Fla., Dec. 1-4.

There will be 125 exhibits there reflecting the latest developments in pharmaceuticals, medical equipment and scientific endeavors.

The Clinical Convention—this will be the 22nd—is one of the best ways of providing continuing education to the busy physician. The scientific exhibits alone are a good postgraduate course in medicine.

And special postgraduate courses will be offered, too, in diabetes, fluid and electrolyte balance and thyroid disease. In addition, there will be about 30 medical motion pictures and scientific television programs will be shown live and in color.

For the physician who likes to discuss the intricacies of his profession, there will be clinical workshops and four breakfast roundtables.

The AMA Clinical Convention is designed primarily for the man in practice. The speakers will read papers that will bring to the practitioner the latest findings of others in his area.

There is an unprecedented emphasis on and need for continuing education. A great manpower shortage has made it mandatory for the physician to expand his knowledge and become more versatile.

The Clinical Convention promises to be a stimulating four days, worthy of the busy physician's time. Every physician is urged to take advantage of this educational opportunity.

AMA Conference to Discuss Community Health Planning

Community Health Planning—the Who, What, When, and How—will be the theme for the American Medical Association's National Conference on Community Health Planning, Nov. 30, in Miami Beach.

Case histories of health planning activities at the state and local levels will be presented during Saturday morning's opening session. These presentations will reflect a variety of goals and approaches as developed in light of local circumstances.

The afternoon program will be devoted to multiple workshops designed to provide a thorough orientation to the actual process of planning—how a community goes about organizing for health planning, assessing needs and resources, defining goals and alternative solutions, and establishing action programs.

The one-day conference is sponsored by AMA's Board of Trustees and the Council on Medical Service and will be held at the Hilton Plaza Hotel.

Additional information may be secured by writing: AMA Department of Community Health, 535 North Dearborn Street, Chicago, Illinois 60610.



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RE-6225



A Proclamation

BY THE GOVERNOR

of the

STATE OF ALABAMA

WHEREAS, The Rural Health Council of Alabama serves to coordinate health activities and programs to interest and encourage the people of Alabama to improve individual, family and community health, by encouraging people to acquaint themselves with health needs, health services, health facilities, and other factors affecting their health; and

WHEREAS, The Rural Health Council provides guidance in development of programs for improvement of health through close liaison with state organizations concerned with such programs, and particularly those organizations whose interests include agriculture and rural life; and

NOW, THEREFORE, I Albert P. Brewer, Governor of the State of Alabama, do hereby proclaim August 19-23 as

RURAL HEALTH WEEK

and urge all the citizens of Alabama to recognize the efforts and accomplishments of the Rural Health Council in the betterment of the health of the rural population of the State of Alabama.

IN WITNESS WHEREOF, I have hereunto set my hand and caused the Great Seal of the State of Alabama to be affixed by the Secretary of State at the Capitol in the City of Montgomery on this the 21st day of August. 1968

Signed: ALBERT P. BREWER

Governor

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Indications: Streptococcus, pneumococcus, and gonococcus infections; infections caused by sensitive strains of staphylococci; prophylaxis of streptococcus infections in patients with a history of rheumatic fever; and prevention of bacterial endocarditis after tonsillectomy and tooth extraction in patients with a history of rheumatic fever or congenital heart disease.

Contraindication: Penicillin hypersensitivity.

Warnings: In rare instances, penicillin may cause acute anaphylaxis which may prove fatal unless promptly controlled. This type of reaction appears more frequently in patients with a history of sensitivity reactions to penicillin or with bronchial asthma or other allergies. Resuscitative drugs should be readily available. These include epinephrine and pressor drugs (as well as oxygen for inhalation) for immediate allergic manifestations and antihistamines and corticosteroids for delayed effects.

Precautions: Use cautiously, if at all, in a patient with a strongly positive history of allergy.

In prolonged therapy with penicillin, and particularly with high parenteral dosage schedules, frequent evaluation of the renal and hematopoietic systems is recommended.

In suspected staphylococcus infections, proper laboratory studies (including sensitivity tests) should be performed.

The use of penicillin may be associated with the overgrowth of penicillin-insensitive organisms. In such cases, discontinue administration and take appropriate measures.

Adverse Reactions: Although serious allergic reactions are much less common with oral penicillin than with intramuscular forms, manifestations of penicillin allergy may occur.

Penicillin is a substance of low toxicity, but it possesses a significant index of sensitization. The following hypersensitivity reactions have been reported: skin rashes ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; and reactions resembling serum sickness, including chills, fever, edema, arthralgia, and prostration. Severe and often fatal anaphylaxis has occurred (see Warnings). Hemolytic anemia, leukopenia, thrombocytopenia, and nephropathy are rarely observed side-effects and are usually associated with high parenteral dosage.

Administration and Dosage: Usual dosage range, 125 mg. (200,000 units) three times a day to 500 mg. (800,000 units) every four hours. For infants, 50 mg. per Kg. per day divided into three doses.

See package literature for detailed dosage instructions for prophylaxis of streptococcus infections, surgery, gonorrhea, and severe infections.

How Supplied: Tablets V-Cillin K® (Potassium Phenoxymethyl Penicillin Tablets, U.S.P.), 125 mg. (200,000 units), 250 mg. (400,000 units), and 500 mg. (800,000 units).

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Pancreatic Pseudocyst Encapsulating Spleen And Presenting As Subphrenic Abscess

Edward H. Laughlin, M. D.

Huntsville, Alabama

Pancreatic pseudocyst large enough to require surgical treatment occurs infrequently; with the result that there are few descriptions of these cysts presenting in an unusual manner or giving rise to uncommon signs or symptoms. Recently we operated on a patient with an unusual pseudocyst, and a review of the literature failed to document a similar case.

Report of Case

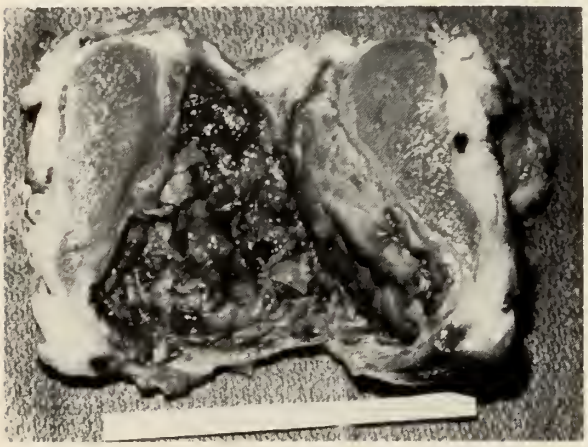
A 29 year-old man, an alcoholic with a previous diagnosis of chronic relapsing pancreatitis, was admitted with epigastric and left shoulder pain, chills, and high fever. One month prior to admission, during the most recent of his eight previous hospital stays, an X-ray study showed a questionable duodenal ulcer. Following his discharge he remained free from pain while following an ulcer regimen and abstaining from alcohol, although he continued to run a low-grade fever despite his being treated with antibiotics. Seventy-two hours prior to admission he noted the gradual onset of his presenting symptoms.

He was a lethargic, dehydrated, Negro with an oral temperature of 40.6 C. There was dullness to percussion over the lower portion of the left side of the chest. The abdomen was flat without tenderness, and hypoactive bowel sounds were present. The liver and spleen were not palpable, and no masses were felt. Laboratory values were: hematocrit, 36 per cent; white blood cell count, 17,400. Serum amylase and 24 hour urine amylase values were normal, as were fasting blood glucose and serum calcium levels. A chest X-ray film indicated a small effusion on the left, and a gastrointestinal series revealed a six cm space between stomach and left diaphragm.

A diagnosis of subphrenic abscess secondary to either pancreatitis or ruptured duodenal ulcer was made, and treatment begun with intravenous fluid and parenteral antibiotics. There followed an immediate drop in fever and a dramatic improvement in his general condition. Six days later at the time of abdominal exploration a firm, rounded, mass measuring 10 x 7 x 6 cm was present

From the division of surgery, Huntsville Hospital. Reprint requests to 800 Gallatin St., Huntsville 35801.

in the left upper quadrant. It was densely adherent to the left diaphragm, upper portion of the greater curvature of the stomach, and splenic flexure of the colon. The tail of the pancreas extended into the mass, and the spleen was not seen. The head of the gland felt normal as did the liver, gallbladder, and duodenum. The lesion including the distal four cm of pancreas was resected.



(Figure) Pancreatic pseudocyst divided to show the normal spleen completely encased within the fibrous wall of the cyst.

After being sectioned the mass was found to be a solitary cyst with a wall encapsulating and compressing normal spleen. The central cavity, lined with friable, shaggy tissue, contained approximately 100 ml of thick, chocolate-like liquid which later grew diphtheroid organisms. Microscopic examination determined the cyst to be of pancreatic origin and not to have an epithelial lining.

After an uneventful recovery from surgery the patient was discharged on the 17th day following admission.

Comment

Pseudocyst is the most common saccular lesion of the pancreas and differs from a true cyst by not having an epithelial lining. The proliferating fibrous tissue comprising the pseudocyst wall usually forms a single cavity which contains a mixture of pancreatic enzymes, hemolyzed blood, and necrotic tissue. Presumably a pseudocyst results from the inflammatory response of peripancreatic tissue to activated enzymes extravasated from the gland; the usual cause being pancreatitis in the adult, and blunt abdominal trauma in the child.[1] Although pseudocysts have been reported to occur in such diverse locations as small bowel mesentery and mediastinum, they usually present within the lesser peritoneal sac, probably because fluid leaking from disrupted pancreas gravitates behind the stomach and above the transverse mesocolon.

Although a pseudocyst can incorporate within its wall structures such as stomach, omentum, or colon, complete encapsulation of the spleen has never been reported. Cattell theorized that the pseudocyst found in an unusual location arises most often from the tail of the pancreas because the distal pancreas is the most mobile portion of the gland.

Symptoms and signs of subphrenic abscess as present in this patient, ie., shoulder pain, chills, fever, and pleural effusion, usually are not evident in the individual with pseudocyst. Jordan,[2] while observing 88 per cent of 150 patients to complain of abdominal discomfort when first examined, could find no individual who presented with shoulder pain. Only 2 per cent of the patients in his series had significant fever; a finding which substantiates the observations of Rhoads,[3] who noted that patients with pseudocyst rarely have chills or fever. The signs of infection present in our patient probably resulted from infection of the pseudocyst, but is unlikely that the diphtheroid bacillus cultured from the cyst contents was the responsible organism. Because the patient had received massive doses of antibiotics during the six days preceding surgery, the pseudocyst was probably sterile, and the organism grown on culture very likely a contaminant.

Pleural effusion associated with pancreatic pseudocyst is rare; only 13 cases having been described in the literature.[4,5] The process by which fluid accumulates above the diaphragm in the presence of a pancreatic pseu-

docyst is unknown. The effusion may result from the physical irritation of the firm cyst upon the undersurface of the diaphragm, or as proposed by Sulavik[6] in an attempt to explain the presence of pancreatic enzymes in the pleural fluid, the exudate may result from the disruption of lymph channels in the diaphragm by proteolytic enzymes, particularly trypsin.

Summary

A case of pseudocyst of the pancreas presented with findings typical of subphrenic abscess: sepsis, shoulder pain, pleural effusion, and subdiaphragmatic mass. The correct diagnosis was not made until laparotomy when an unusual pancreatic cyst encompassing the spleen was found beneath the left diaphragm and successfully resected. There was no evidence of an abscess.

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Referrals For Radiotherapy

W. F. Little, M. D.

Montgomery, Alabama

This article was conceived in an attempt to improve radiotherapy referrals for the three people primarily concerned—the patient, the referring physician and the radiotherapist. The selfish motives of the radiotherapist will be the most obvious if the reader continues, but it is believed that the other two could also benefit from a few preliminary steps.

Too often a patient arrives at the radiotherapist's office unannounced, expecting treatments for what is usually a most serious disease. Possibly he has not even been informed of the true diagnosis, and it can be embarrassing to attempt to drag enough information from a poorly informed patient to proceed even with a preliminary examination, much less to evolve a definite therapy plan. When he isn't aware, for whatever reason, that he has cancer, it compounds the problem. It is absolutely essential that the radiotherapist be provided with a medical resume including the diagnosis, physical findings and results of any surgical procedures that have been done. Also included should be the pathology reports, X-rays showing tumor location, and precise anatomical localization of tumor sites when possible. No definite therapy plan can be worked out without this information, and, if it is available on the first visit, it will save time and nerves.

The second problem that frequently arises is the patient's surprise at the length of time

involved in the treatments. Too often he has been told that he will need "a few X-ray or cobalt treatments," only to be informed later that the "few" really means up to 40 daily treatments. Even though the referring physician cannot know the precise number of treatments, a little better estimate might ease the way for the patient and the radiotherapist.

Generally, for deep seated tumors, the radiation therapy treatments are given daily, either five or six times a week, and generally, each treatment lasts less than one-half hour. The total time involved varies from five to eight weeks depending on the anatomical location and the cell type of the tumor. This includes such malignancies as those of the larynx and pharynx, lung, breast, and female organs. Many of the lymphomas respond readily to smaller total dosage and may require only two to three weeks of therapy. In palliation, such as in bone metastases, the time and dosage may also be reduced considerably when no cure is anticipated. It should be emphasized however, that these are very rough estimates and they vary from one therapy center to another within broad limits.

Superficial therapy for skin lesions varies widely, depending on the size of the lesion. These may require from one to ten treatments at intervals of one to seven days, or an even wider variation may exist for very large lesions.

The importance of this information to the patient, especially to an outpatient from another city is obvious. Either the patient has to arrange to stay in a distant city for five to eight weeks, or has to make long daily trips for this period of time. The importance of this also varies with the patient's general physical condition; that is, whether or not he is physically able to make this many daily trips. Preliminary planning can be important especially if it is necessary that the therapy begin as soon as possible.

The economic factor is also to be considered. No estimate of fees can be made without consulting the individual radiotherapist, but it is obvious that a large number of treatments can represent a financial burden to some patients. Unfortunately, many health insurance policies do not cover radiotherapy. This situation is improving but it is still far from adequate at present. The referring physician or his aide could check the patient's policy in advance to warn him of the possibility that the proposed treatments are not covered by his policy.

A fourth concern of the patient is the effect of the proposed treatments. He could at least be told that the treatments are painless and that no side effects would be expected until the treatments are well under way. Minor side reactions such as nausea can be easily controlled with medication, and generally no sudden changes of any kind occur. This should suffice until specific reactions can be discussed with the radiotherapist. The expected final results of the treatment will, of course, vary with the specific lesion.

Everything discussed so far should be obvious but to those of us involved in radiotherapy, and to the patients themselves they become important and thus deserve a second thought. We sincerely feel that the patient's anxiety could be relieved by a little preliminary discussion of these factors.

Motivation In Chronic Illness

By

Ferdinand F. Schwartz, M. D., F.I.C.A., A.A.P.M.R., M.R.S.H. (England)

"If courage is lost everything is lost better that thou were not born"—Goethe.

In this age of modern civilization with its fast cadence of living, both the mental and the physical stress and strain add more and more burden on humanity. Frustration of hope, seclusion and loneliness of the chronically ill together with the neglect of the so called socially conscious modern generation create a grave problem not only for the patient but also for the physician. The loss of personal frustration cannot be measured but the real damage demands more attention from society. Physical medicine and rehabilitation made a great stride since World War II both in the acute phase and in the after care of the chronically ill. Let us not neglect it but it should be challenged by the medical centers and hospitals throughout the world.

With the increase of our geriatric population, chronic illness, such as strokes, arthritis and neuro-muscular diseases are more prevalent, therefore, assurance and motivation must be given to the man whose life span has increased that he will be able to maintain himself and his family with dignity and self respect in society and in the field of a gainful provider. Why increase life when the happiness of the prolonged years cannot be assured? The impact of physical ailments is tremendous on the patient's nervous system, therefore, the mental aspect of the patient should be considered just as thoroughly as the physical aspect. A busy mind and an occupied body will never nurture the growth of despair, frustration and defeatism. The vigor of the patient is no stronger than the vitality of the will of his physician. Hope awakens courage. He, who can implant courage in the patient has conquered the obstacle.[1]

The chronicity of illness of many of the elderly patients, who occupy the chronic wards of the hospitals, may be in some instances the result of inactivity and neglect.

The superficial facial expression which the patients present is often nothing else but a cover for a perplexed and driven personality and often not even a part of the underlying symptoms of psychosomatic disturbances. Many impulses arise from internal struggles and manifest themselves in anti social behavior. These open antagonisms to adjustment or re-adjustments are often no more than defensive cloak of arms. This may be true in many people who lost the will to develop any resistance to the stagnation which has become their routine of existence. They are shattered and they seek tranquility. Yes, they are anxious, rigid, full of fear and in solitude. They have lost the ability to shoulder oncoming events and therefore, they assume antagonism with the assertion of not cooperating with the physician. Fear and anxiety develop and the reaction is either toward fight or flight. Anxiety more than fear is based on association of a threat to the values of the personality of the individual, to his self esteem or to his security. Most important to human beings is the relationship to one another. These people have been largely deprived of responsibility, which through the years, had paid off in mental and physical inactivity. They have renounced the social responsibility which through the

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Dr. Schwartz is Associate Clinical Professor of Physical Medicine and Rehabilitation, Medical College of Alabama, Birmingham, Alabama.

Paper delivered to the Forty-Fifth Meeting of the Alabama Academy of Science at Samford University, Birmingham, Alabama, April 6, 1968.

years had paid off in personal growth of personality. They fear what they were becoming, the pattern of behavior lost the flexibility of mature adulthood, loss of security with respect of health and being uncared for in illness."[2]

Once he was the king of his house, the good provider, the loving father and now he is imprisoned within the four walls of despair. The mother, who was the absolute ruler over her kitchen, the inspiration to her children, the great cook, the day and night nurse during her children's illnesses, has lost all the contact of the warm embraces and the seals of the fervent kisses. How could she recapture the desire and the motivation toward regaining her regal position in the circle of her family?

Every patient in the hospital must be respected as a human being in spite of his physical and mental defects. They should be guided within their physical and mental capacities in attaining rehabilitation goals through the planning of their physicians. They must be evaluated on an individual basis and in many instances the environment must be changed to suit the patients rather than change the patients to conform to the pattern of the environment.[3] Our world of automation may some day reassess the value of the people for what they are and for what they can accomplish. After all, the machines have no heart or souls, they do not have the biological attributes and the urge of homo sapiens. I personally believe in occasional charities and subsidies but not on the price of rehabilitation and motivation. Independence must be substituted for dependency and society must be helped to adjust itself to the individual. I do realize that we all possess some personal idiosyncrasies and as bad as some of them may be are still accepted by our beloved ones. But let us be thrown in a different environment then the non acceptance of those idiosyncrasies become flames of destruction to motivation. According to Monroe[4] 22 per cent of the old people in his series of 7941 individuals over 61 years of age because of their bodily disease were unable to maintain their grip on normal personality. Therefore, motivation of the patients could be and will be influenced by certain traits within the patient.

No one who is in the field of health care should be too busy to lay his hands on the patient in order to impart his inner warmth to the dying flame of despair frustration.

DON'T FIND FAULT

Pray don't find fault with the man who limps,
Or stumbles along the road:
Unless you have worn the shoes he wears,
Or struggled beneath his load.
There may be tacks in his shoes that hurt,
Though hidden from view
Or the burdens he bears placed on your back,
Might cause you to stumble too.

Don't sneer at the man who is down today,
Unless you have felt the blow
That caused his fall, or felt the shame
That only the fallen know.
You may be strong, but still the blows
That were his, if dealt to you
In the self-same way at the self-same time,
Might cause you to stagger, too.

Don't be too harsh with the man who sins,
Unless you are sure, yea doubly sure
That you have not sins of your own.
For you know, perhaps, if the tempting's voice should
Whisper as soft to you.

—Author not known

Proper bed positioning will aid the patient to be relaxed and contented. Contractures and deformities which often seen could be prevented especially in the stroke patients and the arthritics. A well prescribed and supervised exercise program will increase joint motions, increase circulation and will eliminate waste products. The cells of the body must be nourished through its blood supply which is accomplished through exer-

cises within the limit of the patients' physical, mental and cardio-vascular systems.

In this era of gold rush, inflation, wastes and tranquilizers, we the physicians, together with the ancillary personnel and paramedical groups possess the cheapest, most effortless and inspiring ingredient such as understanding, devotion and dedication to our chronically ill patients.

In order to motivate a patient, he must be carefully examined and evaluated physically, mentally and emotionally. A careful background of his family, his environment, education, religious practice and his employment must be screened in order to achieve the maximum goal in most instances.

Besides good hospital care, good medication and good nursing, the comfort of his family, the devotion of friends and relatives, the inspiring visits of his spiritual leader and his employer may prevent mental and physical deconditioning. Physical medicine and rehabilitation may prevent deformities, contractures, decubitus ulcers, frozen shoulders, confinement to a wheelchair or a bedridden existence. Proper bracing may free him from a solitary confinement and speech therapy may pave the way for communication. Occupational therapy may prove valuable in coordinating movements and vocational rehabilitation may insure an independent livelihood within his physical and mental capacity. A spark of motivation through understanding therapist can dispel the clouds of utter helplessness. The upper extremities in some instances may substitute the functions of the lower extremities and the lower extremities could sometimes take on some of the functions of the upper extremity. Salvage what is left and develop it to its maximum usefulness!

Physical medicine may improve the circulation and reduce edema, may preserve function in the presence of inactivity, may correct and maintain correct body mechanism. It could produce sedative effects by inducing calm in nervous irritability, restlessness and insomnia through controlling pain locally or by producing relaxation in neuromuscular hypertonus. It may further aid in providing mental, recreational and prevocational activities and build tonic effect with reestablishing his identity in his community and society.

Thus, his biologic urges and motives such as survival, self-realization, self-satisfaction, association with others and sex impulses could be aided through team work. That is motivation. Hippocrates said "Life is motion." The lack of motivation in a patient may often be diagnosed through psychiatric and psychologic examinations. A patient with a passive aggressive personality who employs his passivity to influence others may be helped by a dominating and non-manipulative therapist. A patient with a glorified ego often cannot accept his disability or a complete failure in life. The therapist in this case must make the patient maintain his self-esteem and make him realize his condition in order to motivate him. An auto accident patient may develop temper tantrums and may not be able to handle common situations. Therefore, a possible simplification of his living and his environment could make him more sociable and cooperative. Psychologic examination may reveal that some tasks are too difficult for a patient as in vocational re-training or in occupational therapy. In such cases, if the work assigned could be arranged in a simplified outlay, the cooperation of the patient could be achieved. A banker, who was hospitalized for a chronic illness, was assigned to occupational therapy, such as basket weaving. In his concept that was degrading for a banker and he committed suicide.[5]

Motivation could be influenced by the characteristics within the patient, by his ego and by the demand of the therapist which is beyond his physical and mental capacity.

At Partlow school in Tuscaloosa, Alabama, the reward therapy is employed for the mentally retarded and mongoloid patients. If the patient does accomplish the requested exer-

cises or gait training then he is rewarded with candy of his choice. It is like the conditioning reflex. In some instances good cooperation was obtained.

The physiology of motivation, the psychologic motivation and the physiologic drive are but different aspects of the single process of satisfying a biologic need. In hunger, the psychologic desire motivates and the physiologic drive activates search for food. In sex, the psychologic desire motivates and the physiologic drive activates sexual behavior. In fear, the psychologic desire is for safety and the physiologic drive activates flight. In rage, psychologic desire is for victory and the physiologic drive for safety activates to fight. Motivation is the effect experienced when the need drives to action so free will is more precisely affects accompanying behavioral resolution of conflicting drives.[6]

Psychologic support, an outlet for socialization must be furnished both by the physician and the therapist. The small and trivial attributes of the therapist may be the greatest importance to the patient. As Ruskin said, "When we build, let us think that we build forever, let it not be for the present delight, nor the present use alone. Let it be such work as our descendants will thank us for."

Summary

1. The human being is more than a machine, therefore, he must have something to do, something to love and something to hope for in order to be motivated.

2. Never give a patient false hope because it might destroy everything that was to be accomplished.

3. The family is a very important member of the team to achieve maximum results.

4. Adjust society to the patient rather than the patient to the society whenever it is possible.

5. Group competition should be within the patient's physical and mental capacity otherwise defeatism might be developed.

6. Develop speech for communication so that the patient can be in touch with his family and the community.

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Warnings—Watch for the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism, retinal thrombosis); if present or suspected discontinue the drug immediately.

British studies reported in April 1968[1,2] estimate there is a seven- to tenfold increase in mortality and morbidity due to thromboembolic diseases in women taking oral contraceptives. In these controlled retrospective studies, involving 36 reported deaths and 58 hospitalizations due to "idiopathic" thromboembolism, statistical evaluation indicated that the differences observed between users and non-users were highly significant. The conclusions reached in the studies are summarized in the table below:

Comparison of Mortality and Hospitalization Rates Due to Thromboembolic Disease in Users and Non-Users of Oral Contraceptives in Britain.

Category	Mortality Rates		Hospitalization Rates (Morbidity)
	Age 20-34	Age 35-44	Age 20-44
Users of Oral Contraceptives	1.5/100,000	3.9/100,000	47/100,000
Non-Users	0.2/100,000	0.5/100,000	5/100,000

No comparable studies are yet available in the United States. The British data, especially as they indicate the magnitude of the increased risk to the individual patient, cannot be applied directly to women in other countries in which the incidences of spontaneously occurring thromboembolic disease may differ.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or sudden onset of proptosis, diplopia or migraine. Withdraw medication if papilledema or retinal vascular lesions are found.

Since the safety of Ovulen in pregnancy has not been demonstrated, it is recommended that pregnancy be ruled out for any patient who has missed two consecutive periods before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the first missed period.

A small fraction of the hormone agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions—Pretreatment physical examination should include special reference to the breasts and pelvic organs, and a Papanicolaou smear.

Endocrine and possibly liver function tests may be affected by Ovulen. Therefore, it is recommended that such tests if abnormal be repeated after the drug has been withdrawn for two months.

Pre-existing uterine fibromyomas may increase in size under the influence of progestogen-estrogen preparations.

Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation.

In breakthrough bleeding, and all irregular vaginal bleeding, consider nonfunctional causes. Adequate diagnostic measures are indicated in undiagnosed vaginal bleeding.

Carefully observe patients with a history of psychic depression and discontinue the drug if severe depression recurs.

Any possible influence of prolonged Ovulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study.

A decrease in glucose tolerance has occurred in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be observed carefully while receiving Ovulen.

Because of the effects of estrogens on epiphyseal closure Ovulen should be used judiciously in young patients in whom bone growth is not complete.

The age of the patient constitutes no absolute limiting factor, although Ovulen therapy may mask the onset of the climacteric.

The pathologist should be informed of Ovulen therapy when relevant specimens are submitted.

Adverse Reactions—A statistically significant association has been shown between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: cerebrovascular accidents, neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement, secretion), change in weight, changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, allergic rash, rise in blood pressure in susceptible individuals, mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme and nodosum, hemorrhagic eruption, itching.

The following laboratory results may be altered by oral contraceptives: hepatic function: increased sulfobromophthalein and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T^3 values; metyrapone test; pregnanediol determination.

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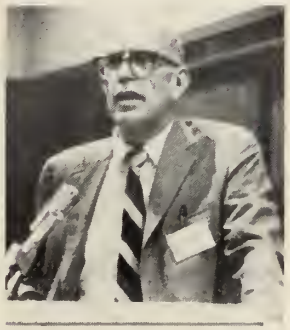
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Urology Society Meets In Birmingham





Dr. William Brannan, guest speaker, shaking hands with Dr. Cecil Morgan, Jr., president, Alabama Urology Society.

Dr. Karl E. Hofammann, Birmingham urologist-gynecologist, speaker.



Dr. Glen Cobbs, instructor, University of Alabama Medical Center, speaker.



Dr. A. Gillespie Diethelm, Brimingham surgeon, and Dr. John R. Woodard, Associate Professor of Urology, U. of A. Medical Center, who described the Renal Transplant program, followed by questions and discussion.



A Sabbath For The Handbook

How two doctors spent a recent Sunday afternoon—poring over plans for a drastically revised Physicians Handbook. The camera caught them in the conference room of the Medical Association building, 19 South Jackson Street, Montgomery. They are Dr. Thomas Riley Lumpkin of Enterprise, president of the Coffee County Medical Society and member of the public relations committee of the Medical Association, and Dr. William Lamar Smith, Montgomery, secretary-treasurer of MASA's Board of Trustees and editor-in-chief of The Journal.



Dr. William Brannan, Ochsner Clinic, New Orleans, guest speaker and panel moderator.



From left: Dr. William Brannan, moderator, and Drs. Carl A. McCandlish, William Cooner (president-elect), and Bruno Barelare, panelists, to discuss "Prostatitis."



Scene in meeting hall . . . . .



Early registrants . . . . .

The Second Alabama Rural Health Conference held in Montgomery on August 21, 1968 was attended by one hundred fifty leaders representing the Medical Association of the State of Alabama, Alabama Department of Public Health, Alabama Farm Bureau, Auburn University Extension Service, Alabama Congress of Parents and Teachers, Alabama Veterinary Medical Association, and Alabama Dental Association, and the Woman's Auxiliary to the MASA.



Seated at speaker's table at Luncheon Session MASA Vice President, left to right—Dr. Frank M. Phillippi, Jr., Brewton; Mrs. Robert K. Wilson, Sr., President, Woman's Auxiliary to MASA, Aliceville; Reverend Henry L. Lyon, Jr., Montgomery; Mrs. John M. Chenault, President-elect, Woman's Auxiliary to AMA, Decatur; Dr. W. Wyan Washburn, luncheon speaker, Past Chairman, AMA Council on Rural Health, Boiling Springs, North Carolina; Dr. Winston A. Edwards, Chairman, MASA Committee on Rural Health, Wetumpka; and Mrs. Winston A. Edwards; Dr. and Mrs. John D. Rayfield, members of Program Committee for the Council, Sylacauga; and Miss Remona Sharp, State 4-H Club Health Project Winner, New Market.



Dr. Wyan Washburn illustrates his speech "from the doctor's bag" at the Luncheon session with the assistance of Miss Deborah Strickland, secretary from the Alabama Department of Public Health.





Dr. John D. Rayfield, Program Chairman.

Dr. Frank M. Phillippi, Jr., speaker at Luncheon session.



Dr. Winston A. Edwards presents an Award Certificate to Miss Remona Sharp of New Market, Alabama, in recognition of her achievement as State 4-H Club Health Project Winner.

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Vital Statistics

NEW MEMBERS

Mobile County

Lowery, John Wayne, b 36, mc Ala. 63, sb 64, 1803 North Wilson Avenue, Prichard, Ala. 36610. Pd.—756-7669.

DEATHS

Jefferson County

Durick, Stephen Anthony, 516 North 18th St., Bessemer, Ala. 35020—deceased August 13, 1968.

Shannon, Paul Wolfe, Woodward Bldg., Birmingham, Ala. 35203—deceased July 31, 1968.

Sherrill, John Doke, 920 S. 18th St., Birmingham, Ala. 35205—deceased June, 1968.

Macon County

Dibble, Eugene Heriot, Drawer DD, Tuskegee Institute, Ala. 36088—deceased June 1, 1968.

Montgomery County

Kaiser, Elias Noah, 2200 Mt. Meigs Road, Montgomery, Ala. 36107—deceased August 22, 1968.

CHANGES OF ADDRESS OF MEMBERS

Baldwin County

Klinner, Kent V., Jr., present Bay Minette, Ala. 36507, to 1308 Preston Street, Opelika, Ala. 36801.

Calhoun County

Woodruff, Gerald G., present Anniston, Ala. 36201, to 940 Montvue Road, Anniston, Ala. 36201.

Elmore County

Hatchett, Benjamin F., Jr., present Millbrook, Ala. 36054, to 1049 Sunset Blvd., Birmingham, Ala. 35213.

Etowah County

Simpson, S. Paul, present Gadsden, Ala. 35901, to 103 South 12th St., Gadsden, Ala. 35901.

Franklin County

Burns, John D., present Russellville, Ala. 35653, to Box 970, Russellville, Ala. 35653.

Underwood, Ralph O., present Russellville, Ala. 35653, to Route 1, Russellville, Ala. 35653.

Ward, William Q., present Russellville, Ala. 35653, to 603 Cranbrook Road, Apt. B, Cockeysville, Maryland 21030.

Jefferson County

Bell, Samuel G., present San Diego, Calif. 92134, to 205 South 8th St., Murray, Kentucky 42071.

Coston, Ralls M., present Birmingham, Ala. 35205, to Jefferson Tuberculosis Sanatorium, 3800 Ridgeway Drive, Birmingham, Ala. 35209.

Johnson, Bruce K., present Birmingham, Ala. 35205, to 2930-12th Avenue North, Birmingham, Ala. 35234.

Nuckols, Frank J., present Birmingham, Ala. 35233, to Box 2896, Birmingham, Ala. 35212.

Poole, Seth W., present Birmingham, Ala. 35205, to 1026 South 17th St., Birmingham, Ala. 35205.

Marion County

Gaba, James E., present Winfield, Ala. 35544, to Suite E, Medical Center, Artesia, New Mexico 88210.

Montgomery County

Durham, Henry S., Jr., present Montgomery, Ala. 36109, to 2900 McGehee Road, Montgomery, Ala. 36111.

MacGuire, Hugh C., present Montgomery, Ala. 36106, to 1005-18th Ave., North, Nashville, Tenn. 37208.

Relfe, Conyers B., present Montgomery, Ala. 36104, to 444 South Hull St., Montgomery, Ala. 36104.

Walker County

Snoddy, William T., Jr., present Jasper, Ala. 35501, to University of Alabama Student Health Service, University, Ala. 35486.

NEW OFFICERS

Clarke County—Board of Censors

W. H. Rudder, M. D., Chairman
J. P. Mudd, M. D.
C. E. May, M. D.
R. W. Larrimore, M. D.

New Telephone Numbers

Cowart, Norton E.—539-9311.

Hodges, E. Julian—574-2553.

Not just a motel
it's a Guest House

. . . with 171 handsome rooms designed for your comfort and convenience. A center-of-everything location including Birmingham's University of Alabama Medical Center . . . making The Guest House a favorite of Doctor's wives and in-town outpatients. Superb dining, dancing and nightly entertainment. Come stay with us often.

THE RESTAURANT
THE PLAYROOM • CYPRESS ROOM
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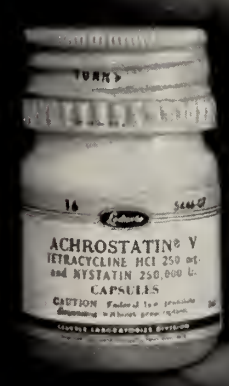


The Guest House
MOTOR INN

PHONE 324-8653
18TH ST. &
10TH AVE., SOUTH
BIRMINGHAM, ALABAMA

"Where the Action Is!"

From the First Family
of Tetracycline–
One of the 31 useful dosage forms
in the ACHRO Family
ACHROSTATIN® V Capsules
Tetracycline HCl 250 mg /Nystatin 250,000 units



The lowest priced
tetracycline-nystatin
combination

Lederle

329-8/6094


Knee-deep

in osteoarthritic pain

If aspirin doesn't help, move in with Tandearil.

The trial period is brief: 1 week. Try one tablet q.i.d. at first. Tandearil usually starts working within 3 to 4 days. When response occurs, as little as 1 or 2 tablets daily may hold back pain and stiffness, and increase joint motion.

On the next page is a summary of adverse reactions, contraindications, warning and precautions.

Tandearil.
It can help get his mind off his knee.

Please review full Prescribing Information carefully before prescribing.

For osteoarthritic knees, spines, shoulders, hips, etc.:

Tandearil®
oxyphenbutazone

Tandearil, oxyphenbutazone:
For brief summary see next page.

Geigy

TA-6006



Tandearil®
oxyphenbutazone

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia The drug should not be given when the patient is senile or when other potent drugs are given concurrently.

Warning: This drug is an analog of phenylbutazone; sensitive patients may be cross-reactive. If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Persistent or severe dyspepsia may indicate peptic ulcer, perform upper gastrointestinal x-ray diagnostic tests if drug is continued. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy Use with caution in the first trimester of pregnancy, and in patients with thyroid disease.

Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patients should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia), sudden weight gain (water retention), skin reactions, black or tarry stools or other evidence of intestinal hemorrhage occur. Make complete blood counts at weekly intervals during early therapy and at 2-week intervals thereafter Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The more common are nausea and edema Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension, the drug should be discontinued with the appearance of edema The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately after meals or with milk to minimize gastric upset. Drug rash occasionally occurs. If it does, promptly discontinue the drug. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), or a generalized allergic reaction similar to a serum sickness syndrome may occur and require permanent withdrawal of medication. Agranulocytosis can occur suddenly in spite of regular, repeated normal white counts. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity angiitis, pericarditis and several cases of anuria and hematuria With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

Dosage in Osteoarthritis: Initial: 3 to 6 tablets daily in divided doses. Usually unnecessary to exceed 4 tablets daily A trial period of one week is considered adequate to determine the therapeutic effect of the drug. Maintenance: Effective level often achieved with 1 or 2 tablets daily, should not exceed 4 tablets daily.

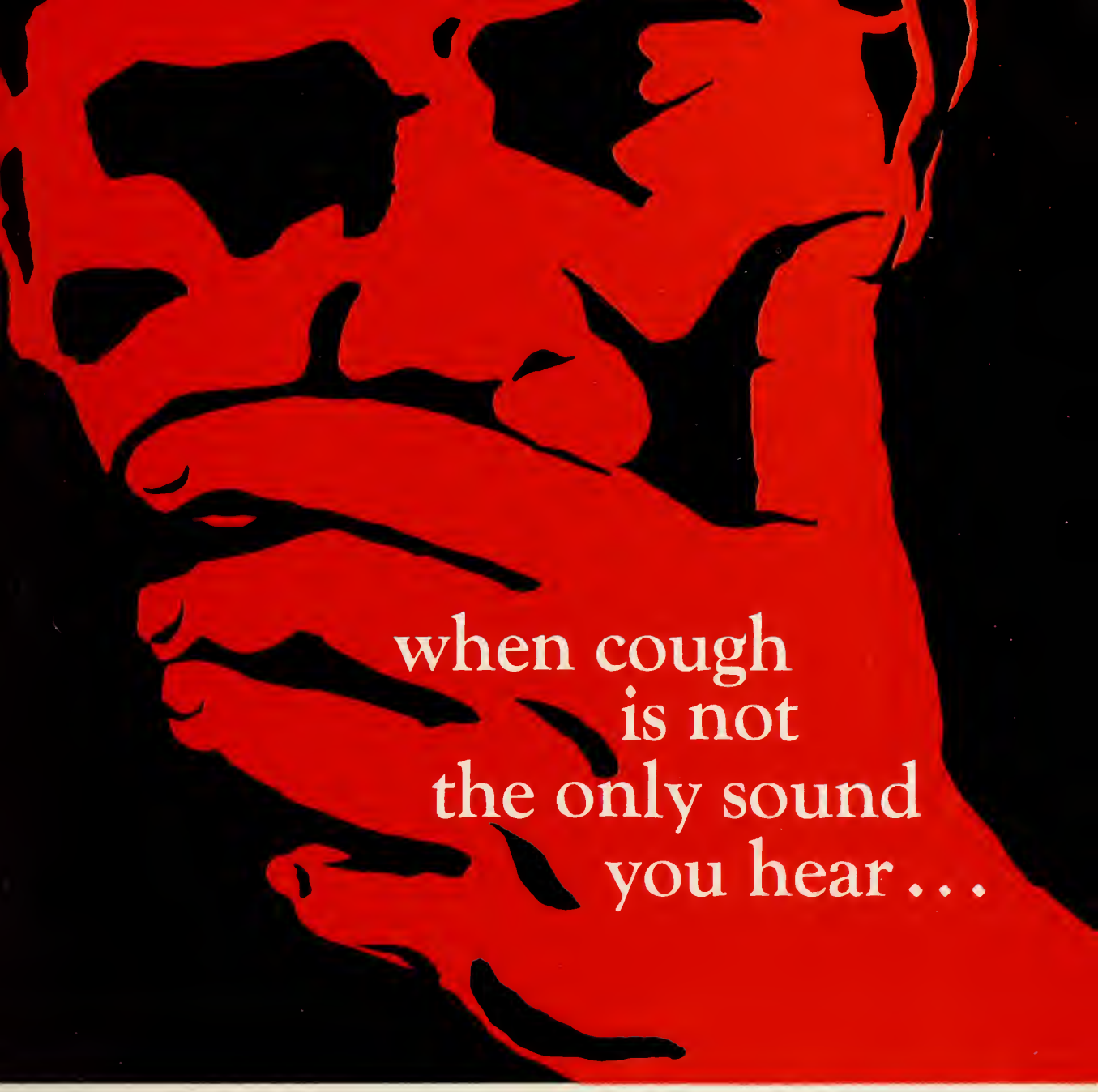
In selecting appropriate dosage in any specific case, consideration should be given to the patient's weight, general health, age and any other factors influencing drug response.

Availability: Tan, round, sugar-coated tablets of 100 mg in bottles of 100 and 1000.

(B)R-46-800-A

For complete details, please see full Prescribing Information.

Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York 10502



OMNI-TUSS® b.i.d.

. . . **because** OMNI-TUSS is indicated for cough associated with upper respiratory tract infections, bronchitis, bronchiectasis, bronchial asthma, emphysema, sinusitis and rhinitis, hay fever, or other allergic conditions. Any of these conditions may exhibit the general symptom syndrome—coughing, wheezing, bronchospasm, and tenacious mucus—which may benefit from the antitussive, bronchodilative, antihistaminic, and expectorant action of Omni-Tuss.

The therapeutic usefulness of Omni-Tuss is enhanced by a unique resin complex formulation providing the clinically desirable advantages of: (1) uniform drug availability throughout an extended period, (2) 8 to 12 hours of symptomatic control, (3) minimal dosage requirement, (4) minimal side effects.

Economical, efficient **b.i.d.** dosage—extremely well-tolerated by children, 6-12, and adults.

'Omni Tuss' Suspension: Each teaspoonful (5 cc.) contains 10 mg. codeine (Warning: May be habit-forming), 5 mg. phenyltoloxamine, 3 mg. chlorpheniramine, 25 mg. ephedrine, all as cation exchange resin complexes of sulfonated polystyrene, and 20 mg. guaiacol carbonate.

Available on prescription only. Class X exempt narcotic. Permissible on oral prescription.

Dosage: *Adults:* 1 teaspoonful (5 cc.) q12h.
Children (6-12 *years*): ½ teaspoonful q12h.

Side Effects: Minimal, but when encountered may include jitteriness, nausea, drying of mouth, insomnia, constipation, which disappear upon adjustment of the dose or discontinuance of treatment.

Precautions and Contraindications: For complete detailed information, refer to package insert or official brochure.

Strasenburgh

Strasenburgh Laboratories Division
Wallace & Tiernan Inc., Rochester, N.Y.

In the complex picture of moderate to severe anxiety...



there is a new reason for prescribing Mellaril (Thioridazine HCl)

effectiveness in mixed anxiety-depression

Long recognized for its usefulness in the treatment of moderate to severe anxiety, Mellaril is now also known to be effective against mixed anxiety-depression.

Often the symptoms of anxiety states are difficult to sort out—even with the most careful probing. The patient may manifest symptoms of agitation, restlessness, insomnia, somatic complaints. But what of the depression that may be mixed in the total picture? It is reassuring to know that Mellaril may be prescribed—with strong possibilities of success—when there is anxiety alone or a mixture of anxiety and depression.

Before prescribing or administering, see Sandoz literature for full product information, including adverse reactions reported with phenothiazines. The following is a brief precautionary statement.

Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.

Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when necessary.

Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving). Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascular System*—Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers, including Mellaril (thioridazine hydrochloride). While there is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients previously showing electrocardiographic changes. The use of periodic electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. *Other*—A single case described as parotid swelling.

Mellaril®
(Thioridazine HCl)
25 mg. t.i.d.

for moderate to severe anxiety and mixed anxiety-depression

SANDOZ SANDOZ PHARMACEUTICALS, HANOVER, N. J. 68-169


on call...
Keflin®
Sodium
Cephalothin
Eli Lilly and Company
Indianapolis, Indiana 46206



"The inconvenience of a cold"

For a cold, NTz® Nasal Spray provides rapid relief of nasal symptoms. Relief starts with the first spray which opens the inferior part of the common meatus. A second spray, a few minutes later, will shrink the turbinates to help provide sinus drainage and ventilation. Dosage may be repeated every three or four hours as needed, for temporary relief of symptoms. NTz is well tolerated but overdosage should be avoided.

As a sinusitis deterrent, NTz Nasal Spray can be used to keep the nasal passages open during a cold to help prevent development of acute sinusitis—or to help prevent the acute condition from becoming chronic.

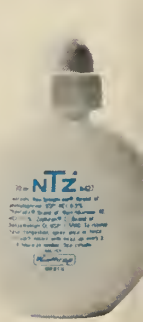
Supplied: NTz Nasal Spray, plastic squeeze bottles of 20 ml.; NTz Nasal Solution, bottles of 30 ml. (1 fl. oz.) with dropper.

NTz is more than a simple vasoconstrictor. It contains

Neo-Synephrine® (brand of phenylephrine) HCl 0.5 per cent, the major component, virtually synonymous with fast, efficient but gentle nasal vasoconstriction.

Thenfadil® (brand of thenyldiamine) HCl 0.1 per cent, topical antihistamine for reduction of rhinorrhea, sneezing or itching. It combats the allergic reactions that may occur in colds or sinusitis.

Zephiran® (brand of benzalkonium, as chloride, refined) 1:5000, antiseptic preservative and wetting agent to promote penetration and spread of the formula.



Winthrop Laboratories, New York, N.Y. 10016 Winthrop

Alabama Department of Public Health

Continuing Education Experiment Enters Second Year

By

Catherine G. Lamar

On October 1, Alabama embarked upon the second year of participation in the Continuing Education Project designed to provide educational sessions for public health workers utilizing educational television, study manuals, and group discussions.

The Southern Regional Office of the American Public Health Association initiated the project in 1966 under a U. S. Public Health Service grant acquired for the purpose of planning and producing programs and materials for the continuing education of public health workers. The project has as its objective the improvement of the delivery of better health services.

Designed to span a three-year period, the pilot project included three states: Alabama, Louisiana, and North Carolina. Alabama became the first of the three to begin the program when on September 26, 1967, public health workers throughout the state began viewing weekly 30-minute ETV programs and participating in half-hour discussion periods following each program.

During 1967, 29 programs were televised. Out of approximately 1500 public health workers in Alabama, 79 per cent participated in one or more of the sessions, 85 per cent in 11 or more sessions, and 66 per cent in 21 or more sessions. Fifty-four of the 67 county health departments had at least one television set available to staff members; 7 of those not having sets were outside the TV receiving range. It is significant to note that prior to initiation of the project only 9 counties had TV sets.

Several types of evaluative data were compiled during the year on selected aspects of the project in an attempt to obtain opinions from participating public health workers and other basic information relative to the program. As a result of this survey, several changes have been made in planning and programming for 1968. The most significant change resulting from the survey involved frequency of viewing. Beginning in October, public health personnel will view and discuss programs on a bi-monthly rather than a weekly schedule. The same program, however, will be shown two weeks in succession to allow for maximum participation. Sessions are scheduled for Tuesday, at 4 P. M., and Wednesday, at 8 P. M. each week through January. Beginning January 29, programs will be viewed at 8 A. M. on Tuesday, and at 3 P. M. on Thursday. This schedule will be adhered to until completion of the Project Year.

Other significant results of the survey include:

82 per cent felt that the Continuing Educa-

(Continued on Page 357)

This advertisement for TAO® (triacetyloleandomycin), published at the request of the Food and Drug Administration, replaces a recent one which the FDA regards as misleading.

The advertisement headlined "new evidence for TAO . . ." and emphasized that the drug is "for the frequently seen respiratory infection in the office and for a problem pathogen* in the hospital. *Staphylococcus aureus."

We emphasize that triacetyloleandomycin is to be used only for acute, severe bacterial infections where adequate sensitivity testing has demonstrated susceptibility to this drug and resistance to other less toxic agents. In view of the possible, but reversible, jaundice and hepatotoxicity of this drug, other less toxic agents should be used unless the organism is resistant to those agents, or in those cases where hypersensitivity precludes their use.

TAO is contraindicated in preexisting liver disease or dysfunction, and in individuals who have shown hypersensitivity to the drug.

The advertisement emphasized that no tooth staining has been reported after ten years of use of this antibiotic. The Food and Drug Administration regards this claim as an implied comparison suggesting that triacetyloleandomycin and tetracycline have a similar antibacterial spectrum of effectiveness, and that TAO has less toxic potential. Any such implication is not intended and, of course, would be invalid.

The advertisement referred to a research study in which patients were given triacetyloleandomycin prior to determining the susceptibility of the offending organism. Any suggestion that triacetyloleandomycin be used clinically without first determining susceptibility of the offending organism should be disregarded.



J. B. ROERIG DIVISION
CHAS. PFIZER & CO., INC.
235 EAST 42nd STREET
NEW YORK, N.Y. 10017

TAO®(triacetyloleandomycin)
Brief Summary

INDICATIONS: Include streptococci, staphylococci, pneumococci and gonococci. Recommended for acute, severe infections where adequate sensitivity testing has demonstrated susceptibility to this antibiotic and resistance to less toxic agents.

CONTRAINDICATIONS: Contraindicated in pre-existing liver disease or dysfunction, and in individuals hypersensitive to the drug.

PRECAUTIONS: CAUTION: USE OF THIS DRUG MAY PRODUCE ALTERATIDNS IN LIVER FUNCTION TESTS AND JAUNDICE. CLINICAL EXPERIENCE AVAILABLE THUS FAR INDICATES THAT THESE LIVER CHANGES WERE REVERSIBLE FDLLOWING DISCONTINUATIDN OF THE DRUG.

Not recommended for prophylaxis or in the treatment of infectious processes, which may require more than ten days continuous therapy. In view of the possible hepatotoxicity of this drug when therapy beyond ten days proves necessary, other less toxic agents should be used. If clinical judgment dictates continuation of therapy for longer periods, serial monitoring of liver profile is recommended, and the drug should be discontinued at the first evidence of any form of liver abnormality. When treating gonorrhea in which lesions of primary or secondary syphilis are suspected, proper diagnostic procedures, including dark-field examinations, should be followed. In other cases in which concomitant syphilis is suspected, monthly serological tests should be made for at least four months. When used in streptococcal infections, therapy should be continued for ten days to prevent the development of rheumatic fever or glomerulonephritis. The use of antibiotics may occasionally permit overgrowth of nonsusceptible organisms. A resistant infection or superinfection requires re-evaluation of the patient's therapy. In the event such occurs with this drug the medication should be discontinued, and specific antibacterial and supportive therapy instituted.

ADVERSE REACTIONS: Although reactions of an allergic nature are infrequent and seldom severe, those of the anaphylactoid type have occurred on rare occasions.



J. B. ROERIG DIVISION
CHAS. PFIZER & CO., INC.
235 EAST 42nd STREET
NEW YORK, N.Y. 10017

(Continued from Page 355)

tion Program had been beneficial to them

79 per cent felt that the combination of study manual, TV program, and discussion periods were an effective learning experience

80 per cent felt that educational TV should be recommended as a useful way of conducting programs for public health workers

65 per cent indicated that they looked forward to participating in the next series of Continuing Education ETV programs

57 per cent indicated that they had a better understanding of their job as a result of these programs

82 per cent felt that they had a better understanding of the work of other staff members

56 per cent felt that they are providing better services to clients and/or the health department

Topics for the upcoming year's series of programs were selected by the state Continuing Education Committee in conjunction with an advisory committee composed primarily of teachers of public health. Subjects for some of the programs include: Health Planning, Mental Health, Smoking and Health, The Family and Society, The Child from Birth to School, School Health Programs, Health Education, Dental Health, New Immunization Procedures, Air and Water Pollution, Environment of the Aging, Practical Statistics, Medical Care, Innovations in the Delivery of Health Services, Looking to the Future in Public Health, and Summary of Alabama Survey.

During the summer, a workshop was held to train key personnel involved with the project. Discussion coordinators and leaders, recorders, and resource persons from county health departments and the Alabama Department of Public Health attended workshops scheduled in five geographic locations: Decatur, Birmingham, Montgomery, Dothan, and Mobile.

BUREAU OF VITAL STATISTICS
PROVISIONAL BIRTH AND DEATH STATISTICS AND COMPARATIVE DATA
Ralph W. Roberts, M. S., Director
JUNE 1968

Live Births / Deaths / Causes of Death	Number Registered During June 1968			Rates* (Annual Basis)		
	Total	White	Non-White	1968	1967	1966
Live Births	4,991	3,316	1,675	16.9	16.8	16.1
Deaths	2,546	1,698	848	8.6	8.0	8.3
Fetal Deaths	100	51	49	19.6	24.6	24.2
Infant Deaths						
under one month	96	50	46	19.2	18.5	19.7
under one year	121	64	57	24.2	26.3	27.8
Maternal Deaths	2	1	1	3.9	2.0	6.3
Causes of Death						
Tuberculosis, 001-019	14	6	8	4.7	5.1	6.9
Syphilis, 020-029	8	3	5	2.7	1.0	1.7
Dysentery, 045-048						
Diphtheria, 055						
Whooping cough, 056						
Meningoeoccal infections, 057	1	1		0.3	1.0	
Poliomyelitis, 080, 081	1+	1		0.3	0.3	0.3
Measles, 085	1		1	0.3		0.3
Malignant neoplasms, 140-205	378	260	118	128.0	120 5	111.6
Diabetes mellitus, 260	40	24	16	13.5	14.7	15.2
Pellagra, 281						
Vascular lesions of central nervous system, 330-334	363	214	149	122.9	98.0	102.3
Rheumatic fever, 400-402					0.7	
Diseases of the heart, 410, 443	844	618	226	285.7	264.0	305.1
Hypertension with heart disease, 440-443	80	36	44	27.1	32.4	40.8
Diseases of the arteries, 450-456	56	37	19	19.0	16.0	17.3
Influenza, 480-483	2	1	1	0.7	1.0	0.7
Pneumonia, all forms, 490-493	43	29	14	14.6	13.7	14.9
Bronchitis, 500-502	7	4	3	2.4	0.7	1.7
Appendicitis, 550-553					0.3	1.4
Intestinal obstruction and hernia, 560, 561, 570	8	7	1	2.7	2.4	4.8
Gastro-enteritis and colitis, under 2, 571.0, 764	2		2	0.7	1.0	2.1
Cirrhosis of liver, 581	19	15	4	6.4	4.1	6.2
Diseases of pregnancy and childbirth, 640-689	2	1	1	3.9	2.0	6.3
Congenital malformations, 750-759	21	19	2	4.2	5.7	4.1
Immaturity at birth, 774-776	31	15	16	6.2	5.9	6.8
Accidents, total, 800-962	229	170	63	77.5	67.6	62.5
Motor vehicle accidents, 810-835, 960	131	103	28	44.3	32.8	31.1
All other defined causes	342	212	130	115.8	121.2	112.6
Ill-defined and unknown causes, 780-793, 795	134	62	72	45.4	48.5	40.8

+ late effects

*Rates: Birth and death—per 1,000 population
Infant deaths—per 1,000 live births
Fetal deaths—per 1,000 deliveries
Maternal deaths—per 10,000 deliveries
Deaths from specified causes—per 100,000 population

BUREAU OF LABORATORIES
Thomas S. Hosty, Ph.D., Director
AUGUST 1968

Examination of Intestinal Parasites	1,989
Examination of Malaria	6
Examination of Salmonella & Shigella (blood-feces-urine-food)	406
Examination of tubercle bacilli	4,641
Examinations for gonococci	1,857
Serological tests for Syphilis	37,436
FTA	130
Darkfield	0
Brucella	0
General Bacteriology (cultures for isolation and confirmation)	22
Staphylococcus (cultures for isolation and confirmation)	7
Examinations for diphtheria (cultures for isolation and confirmation)	117
Streptococci examinations	2,208
Mycology	64
Agglutinations	24
Vincent's Infection	7
Complement fixation tests	197
Tests for Phenylketonuria (PKU)	7,092
Cytology	2,523
Water Examinations	4,328
Milk and Dairy Products examinations	6,172
Sea Food Examinations	166
Examinations for Negri bodies (smears & animal inoculations)	300
Virology	22
Rh Factor Bloods	857
Miscellaneous	1,389
Gonococcus Study	1,598
TOTAL	73,558

Tuberculosis? Influenza?
Pneumonia? Leukemia?
Hodgkin's Disease? Syphilis?
Systemic Fungal Diseases?
Chronic Chest Diseases?
or
HISTO?
(Histoplasmosis—"The Masquerader")



A new aid in differential diagnosis
HISTOPLASMIN, TINE TEST
(Rosenthal)
The LEDERTINE™ Applicator with the Blue Handle

Precautions—Nonspecific reactions are rare, but may occur. Vesiculation, ulceration or necrosis may occur at test site in highly sensitive persons. The test should be used with caution in patients known to be allergic to acacia, or to thimerosal (or other mercurial compounds).

Lederle

Ask your representative for details or write Medical Advisory Dept., Lederle Laboratories, Pearl River, New York 10965. 406-8



NEW! THE RITTER COAGULATOR

from the makers of the famous Bovie electrosurgical units . . .

The Ritter Coagulator is a low-in-cost but high-in-quality electrocoagulation instrument for wall or shelf service in your office. Made by the makers of the famous hospital Bovie, it has been engineered to utilize every advantage of today's advanced state of electronic circuitry. It will coagulate, desiccate and fulgurate—and you can handle scores of day-to-day applications in dermatology, gynecology, rhinolaryngology and proctology. Easy, safe to operate. Compact—only 8½ x 5 x 4 inches. Ask for a demonstration.

DURR

Surgical Supply Co.

MONTGOMERY BIRMINGHAM HUNTSVILLE



Pork Is Health—A Challenging View

William C. Sherman, Ph. D.

Director, Nutrition Research, National Live Stock and Meat Board

Chicago, Illinois

Unfortunately there are many "old wives' tales" about pork which are still prevalent in the minds of both consumers and many people in the health professions which are completely without scientific foundation. These untruths detract from the excellent image that pork should have from a health standpoint.

Beef and lamb enjoy a favorable image as good sources of protein, minerals and vitamins, but pork too often is considered to be a fatty food. This idea prevails because old tables of food composition still in use were based on early research on meat and for the most part only raw, untrimmed cuts of meat were considered. With the production of the lean type pork and the careful trimming of most of the visible fat from retail cuts by the packers and retailers, it is well established that the lean portion in pork is no higher in calories than is beef and lamb. Pork is just as rich in high quality protein, the important mineral iron and the B vitamins, riboflavin and niacin as other meats and is the richest food source of the B-vitamin, thiamine.

Many health workers frown upon the use of pork for patients on various types of special diets. For overweight patients or those recovering from ulcers or with problems of the digestive tract, pork is not permitted by many health professionals because they have the misconception again that pork is high in fat or that the fat of pork is indigestible or hard to digest. *There is no evidence to support this misconception.* A set of diet leaflets making full use of pork has been worked out with the cooperation of the American Dietetic Association and the American Medical Association.

It is generally recognized that pork contains animal fat, that animal fat is more saturated than vegetable oils and that lowering the consumption of animal fat and increasing that of vegetable oils will produce a modest lowering of blood cholesterol levels. The question is whether this lowering of blood cholesterol by dietary means will do any good as far as heart disease is concerned.

Variables Other Than Fat

In spite of years of research work to evaluate the possible effect of lowering saturated animal fat in the diet and replacing it with polyunsaturated vegetable oil, there is still no valid evidence that the modest lowering

of blood cholesterol so produced will be in any way beneficial in lowering the incidence of heart disease in humans. It is believed that the main reason for the confusion and conflicting results is the lack of appreciation of the necessity to eliminate from experiments important variables other than type of fat. The variable which is most frequently not controlled is the degree of overweight and changes in weight during the course of the experiment. In all experiments where overweight has been controlled, substitution of vegetable oils has either had no effect or has increased the incidence of heart attacks. In all studies which upon cursory examination might appear to indicate a reduction in heart disease with fat modified diets, the overweight condition in the diet groups was intentionally or accidentally corrected while nothing was done about the overweight condition of the "control group." Other pertinent factors were also not controlled in some of the studies.

Because of the problem of obesity in this country, it is obvious that it is desirable to restrict calories of all types—carbohydrates as well as fats for many people.

I would even agree that it is desirable for weight-watchers to restrict the intake of animal fat while maintaining a good meat-centered high protein diet. However, if one is successful in cutting back 500 calories a day by restricting animal fat, I would seriously question the desirability of adding back 500 calories in the form of vegetable oils.

Less, Fat, More Vegetable Oils

Statistical data on animal fats and vegetable oils consumption indicates that the American public since 1940 has already been doing, to a degree, what the American Heart Association is recommending: consuming less animal fat and more vegetable oils. The very fact that heart disease as a cause of death has drastically increased in the same period of time in which Americans have eaten more vegetable oils and less animal fat would indicate that the Heart Association's recommendations are based on very shaky scientific evidence. If dietary fat is a factor, it would appear that the Heart Association is shooting at the wrong target. It's the highly-publicized, fervently-advertised polyunsaturated vegetable oils that Americans are eating more of . . . not saturated animal fats.

The only health association which recommends that the general public should adopt fat-modified diets and is giving widespread publicity to fat-modified diets is the American Heart Association which derives its financial support from contributions from the general public. All other associations, government agencies and professional societies such as the American Medical Association, Food and Nutrition Board of the National Research Council, U. S. Public Health Association, American Dietetic Association, American Institute of Nutrition, National Institutes of Health, Food and Drug Administration and the U. S. Department of Agriculture are in agreement in recognizing the seriousness of heart disease but recognize the lack of sufficient evidence to make recommendations concerning the optimum amount or type of fat for the diet of the general public. They also recognize the possible hazards to health in making such recommendations if nutritional balance is not maintained.

Summary

There is no basis, in fact, for the image that pork has in the eyes of some members of the health professions. Pork is lean meat, is an excellent source of high quality protein, minerals and B vitamins. It is no higher in fat and calories than other types of lean meat and is an excellent food for generous use in weight reduction diets. Pork is highly digestible and should be included in diets for patients who are recovering from ulcers and for those with many types of digestion problems. There is no valid evidence that restricting the use of pork and replacing animal fat with polyunsaturated vegetable oils will help prevent heart attacks. In fact, there is evidence that this dietary change will have no effect or will increase the incidence of heart attacks.

Report Reviews Progress In Treating, Rehabilitating Disabled

The "orthopedically and functionally disabled" in Alabama, numbering approximately 134,000, are the subject of a survey and study just completed by a State Planning Committee headed by L. R. Priest, Administrator, Alabama Rehabilitation Center, as chairman.

Arthritis and Rheumatism, with 60,300 victims listed in state programs by the most recently available report (1961-63), runs a close second to chronic conditions affecting the upper and lower extremities (the spine), with 61,000 victims. In this table, Paralysis, either complete or partial, accounts for 16,400, while other diseases of muscles, bones and joints tally 14,600.

An interesting table from the Crippled Children's Service shows 10,184 receiving service in 1967, with visual defects the leading crippling condition requiring help, with 2,564 patients. "Pronation of feet" was second with 2,160, while other leading causes were Cerebral Palsy, 1,997; Hearing loss, 1,808; and Epilepsy, 1,264.

Rehabilitation of the physically handicapped is much easier to accomplish than that of the mentally or socially handicapped, and the contrast between the annual earnings of the disabled before rehabilitation ($313.56) and afterwards ($2,532.92) was statistical justification for such programs.

Treatment philosophies of the orthopedically and functionally disabled are summarized in three categories, in the report: Corrective, Supportive and Custodial, and the agencies serving them are divided into public (of which the report listed 11 county, state and federal agencies), private (local general practitioners and medical specialists), and volunteer agencies (divided into ten groups).

The report noted the steadily rising per-person cost for services, from $552 in 1961 to $1,059 in 1967. It made a summary projection of the service expansion to 1975, through Medicaid, Vocational Rehabilitation Service and other Federal-State programs, estimated that by that year 146,000 persons in Alabama would be in this disability group, and, while generally optimistic, offered a series of recommendations.

Specifically, the Committee urged a Disease Control Program for Arthritis, an inpatient custodial facility for Cerebral Palsy, follow-up care for Epilepsy, untiring nursing care for Paraplegics, and the biennial publication of a directory to supply physicians with the name, location, and details of admission of all certified and approved convalescent facilities and domiciliary facilities in the State, complete with cross-index.

Eleven barriers to client placement are significant. In one-two-three order, they are: Architectural barriers, minimum wage laws, workmen's compensation laws, group insurance coverage (whereby coverage for a handicapped person might result in increased premium for every employee), educational background, client attitude toward job responsibility, family attitude, inadequate training, age, lack of public relations effort, and finally, No. 11, poor placement efforts.

Eight specific recommendations concluded the report:

1. Establish a registry of all handicapped persons within the State.
2. Publish directory of available services and facilities within the State.
3. Establish an Agency Coordination Council.
4. Acceleration of recruitment and training of professional and technical personnel.
5. Establishment of equipment loan centers throughout the State.
6. Recognition of a Permanent Committee to promote services for the Orthopedi-

(Continued on Page 369)

A once-popular treatment for back pains was to have the seventh son of a seventh son stand or walk on the patient's back.





The pain of earache was allegedly relieved by holding a hot roasted onion to the ear.

For headache, a sovereign remedy was to wear a snakeskin round one's head.



A realistic approach to pain relief



Empirin'®

Compound with Codeine Phosphate gr. 1/2 No. 3

Each tablet contains:
Codeine Phosphate gr. 1/2 (Warning—May be habit forming), Phenacetin gr. 2 1/2, Aspirin gr. 3 1/2, Caffeine gr. 1/2.

keeps the promise of pain relief

'B.W. & Co.' narcotic products are Class "B", and as such are available on oral prescription, where State law permits.

BURROUGHS WELLCOME & CO. (U.S.A.) INC.
Tuckahoe, N.Y.

New

Therapeutic breakthrough in non-narcotic control of the pain of trigeminal neuralgia

Tegretol®
carbamazepine

Warning
Fatal cases of aplastic anemia have been reported following treatment with Tegretol. Agranulocytosis, thrombocytopenia and transitory leukopenia have also been observed.
Complete blood and platelet counts should be done prior to and at regular intervals during treatment with the drug (see recommendations under "Important Note and Precautions") to help in the early detection of serious bone marrow injury. Abnormalities in initial blood tests should rule out use of the drug. Also, patients should be made aware of such early toxic signs of a potential hematologic problem as fever, sore throat, mouth ulcers, easy bruising and petechial or purpuric hemorrhage. Should such signs appear, the patient should be advised to discontinue the drug and to report to the physician immediately.

Indication Tegretol is indicated in the treatment of the pain associated with true trigeminal neuralgia. It is not a simple analgesic and should never be administered for relief of trivial facial aches or pains.
Contraindication Do not use in those with a known sensitivity to any tricyclic compound or in those being treated with M.A.O.I. agents. As long a period as possible should elapse before using Tegretol in patients who have been treated with M.A.O.I.'s, with a minimum of 7 days. In such cases, initial dosage should be low and the patient's reaction to gradual increments closely observed.
Important Note and Precautions Familiarity with the clinical symptoms which lead to an accurate diagnosis of true trigeminal neuralgia and with the complete prescribing information, careful patient selection, a thorough examination before treatment and close patient supervision throughout the treatment period are essential to the safe and effective use of this drug.
Where feasible, Tegretol should not be used in conjunction with any potent drug which may increase the possibility of toxic reactions.
In pregnancy, the drug should not be prescribed during the first trimester and thereafter only to patients in whom the clinical situation warrants the potential risk. It should not be administered to nursing mothers.
Patients with increased intraocular pressure should be closely observed during treatment with this drug because of its anticholinergic effect.
Because of the drug's relationship to other tricyclic compounds, the possibility of activation of latent psychosis and, in the elderly, of confusion or agitation, should be considered.
Dizziness and drowsiness may occur and patients should be cautioned about the hazards of operating machinery or automobiles and of engaging in other hazardous tasks.
Use cautiously in patients with a history of coronary artery disease, organic heart disease, congestive failure or liver disease.
Before initiating therapy, the following laboratory procedures should be performed:
1. Complete blood and platelet counts which, if abnormal, should rule out the use of the drug.
2. Baseline evaluations of liver function.

During treatment with Tegretol, the following laboratory procedures should be performed:
1. Complete blood and platelet counts should be done at intervals of one week during the first month of drug treatment, every two weeks during the second and third months, and at monthly intervals thereafter for as long as the patient is taking the drug. A trend toward a decreasing white blood cell count should suggest a dosage reduction and more frequent laboratory and clinical evaluations. Should this trend continue, the drug should be discontinued.
2. Liver function tests must be performed at regular intervals during trea ment with this drug since liver damage may occur during therapy. The drug should be discontinued immediately in cases of aggravated liver dysfunction or active liver disease.
3. Periodic eye examinations, including slit-lamp, funduscopy and tonom etry, are recommended for patients being treated with this drug since many phenothiazines and related drugs have been shown to cause eye changes.
4. Complete urinalysis and BUN should be done on patients treated wit Tegretol because of observed renal dysfunction.

Adverse Reactions Dizziness, drowsiness, unsteadiness on the feet, nausea, vomiting, aplastic anemia, transitory leukopenia, agranulocytosis eosinophilia, leukocytosis, thrombocytopenia, purpura, abnormalities in liver function tests, cholestatic and hepatocellular jaundice, urinary frequency, acute urinary retention, oliguria with elevated blood pressure, albuminuria, glycosuria, elevated BUN, microscopic deposits in the urine impotence, disturbances of coordination, confusion, headache, fatigue, blurred vision, transient diplopia and oculomotor disturbances, speech disturbances, abnormal involuntary movements, peripheral neuritis and paresthesias, depression with agitation, talkativeness, nystagmus, tinnitus, paralysis and other symptoms of cerebral arterial insufficiency, pruritic and erythematous rashes, urticaria, Stevens-Johnson syndrome, photosensitivity reactions, alterations in skin pigmentation, exfoliative dermatitis, alopecia, diaphoresis, recurrence of thrombophlebitis, erythe multiforme and nodosum, aggravation of disseminated lupus erythematosus, gastric distress, abdominal pain, diarrhea, constipation, anorexia, dryness of the mouth and pharynx, glossitis, stomatitis, fever, chills, adenopathy, lymphadenopathy, aching joints and muscles, leg cramps, conjunctivitis, left ventricular failure, aggravation of hypertension, hypotension, syncope and collapse, edema, aggravation of coronary artery disease and congestive heart failure. (Whether these cardiovascular effe are drug-related is not known. However, some of these complications ha resulted in fatalities.) The necessity for discontinuing the drug should be dictated by the gravity and severity of the adverse reactions.

Dosage and Administration The drug should always be taken with meals if possible.
Initial: One-half tablet (100 mg.) b.i.d. on the first day. Thereafter, the dos should be increased in one-half tablet (100 mg.) increments every 12 hou until freedom from pain is achieved. To relieve pain, between 200 mg. an 1200 mg. per 24 hours may be necessary.
Maintenance: Initial control of pain can be maintained in most patients with a dose of 400 mg. to 800 mg. daily. Maintenance doses may range between 200 mg. and 1200 mg. daily.
At least once every 3 months during treatment period attempts should be made to discontinue the drug or to reduce the dose to the minimum effective level.

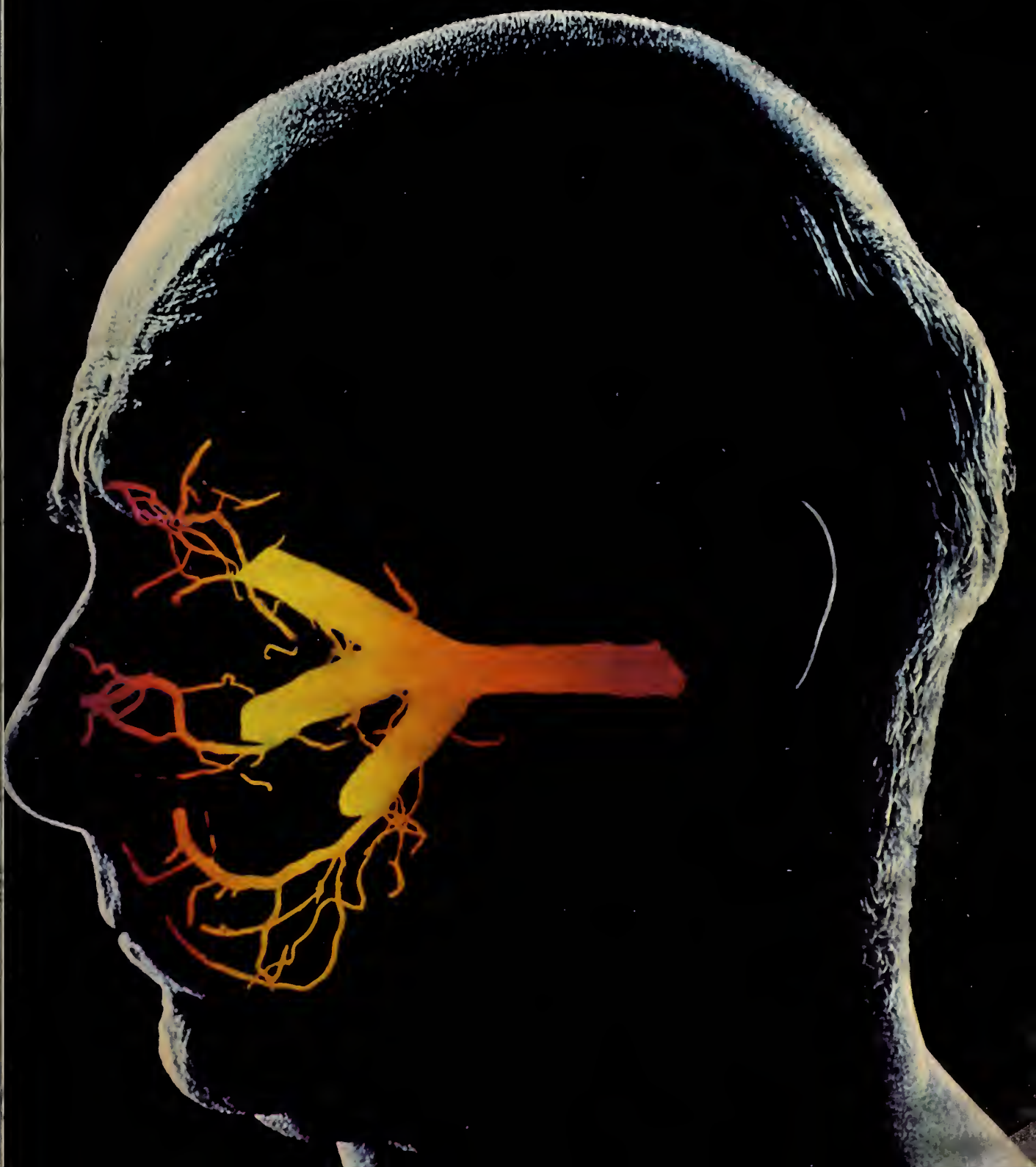
Availability Round, white, single-scored tablets of 200 mg. in bottles of 100 and 1000. (B)46-820-A

For complete details, please see Prescribing Information.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

Geig

uncommon relief of uncommon pain



The Divorced Depressive: "Forty, Forgotten

"Had a large wedding."
"Had a fine home and family."



TO-5757

.Forlorn"

"Had a divorce."
"I'm a real loser,
and so are
the kids."



in depression

The loss of marital compatibility results in nearly 500,000 U.S. divorces each year.

Depression characterized by untold guilt feelings, grief and loneliness may follow.

When you diagnose depression, Tofrānil may be indicated for relief.

As maintenance therapy during the active phase of depression, Tofrānil can often help prevent relapse.

The use of Tofrānil in patients receiving M.A.O.I.'s is contraindicated. In patients with cardiovascular disease, thyroid disorders, increased intraocular pressure; in those receiving anticholinergics (including antiparkinsonism agents), thyroid medication or antihypertensive adrenergic neuron-blocking agents; and in those in their first trimester of pregnancy–the special precautions listed in the Prescribing Information should be carefully observed.

Toxic reactions severe enough to require discontinuation of Tofrānil are uncommon. However, for complete details, please refer to the complete Prescribing Information.

Turn page for brief summary of Prescribing Information.

Tofrānil® imipramine hydrochloride
Geigy

in depression





Tofrānil® Geigy

imipramine
hydrochloride

Tofrānil®, imipramine hydrochloride
Indications: Tofrānil is recommended for the treatment of depressive states of diverse psychopathology.
Contraindications: The concomitant use of this agent and monoamine oxidase inhibiting (M.A.O.I.) compounds is contraindicated. Hyperpyretic crises or severe convulsive seizures may occur. Potentiation of adverse effects can be serious or even fatal. An interval of at least 7 days after M.A.O.I. therapy has been discontinued should be allowed before this drug may be substituted. Initial dosage should be low, increases should be gradual, and the patient's progress should be carefully observed.
Warning: Clinical reports have suggested that there may be a risk of teratogenesis associated with the use of this compound during the first trimester of pregnancy. Unless, in the opinion of the prescribing physician, the potential benefits outweigh the possible risks, it should not be used during the first trimester of pregnancy. Cardiovascular complications, including myocardial infarction and arrhythmias, have occasionally occurred in susceptible individuals. Patients with cardiovascular disease should be given the drug only under careful observation and in low dosage.
Precautions: Since suicide is always a possibility in severely depressed patients and one which may persist until significant remission occurs, such patients should be carefully supervised during early treatment. Some severely depressed patients may also require hospitalization and/or concomitant electroconvulsive therapy. Because of its anticholinergic effect, caution should be observed in prescribing the drug for patients with increased intraocular pressure.
In rare instances, transient cardiac arrhythmias have occurred in hyperthyroid patients and in patients receiving thyroid medication when this compound was added to the regimen. Imipramine may block the pharmacologic activity of guanethidine and other related adrenergic neuron-blocking agents.
The drug is not recommended at the present time in patients under 12 years of age.
Adverse Reactions: Dryness of the mouth, tachycardia, constipation, disturbances of accommodation, sweating, dizziness, weight gain, urinary frequency or retention, nausea and vomiting, peripheral neuritis, mild parkinson-like syndrome, tremors, rare cases of falling in elderly patients, confusional states (with such symptoms as hallucinations and disorientation), activation of psychosis in schizophrenics and agitation (including hypomanic and manic episodes) which may require dosage reduction and/or addition of a tranquilizer or temporary discontinuation of the drug, epileptiform seizures, orthostatic hypotension and substantial blood pressure fall in hypertensive patients, purpura, transient jaundice, bone marrow depression including agranulocytosis, sensitization and skin rash including photosensitization, eosinophilia, and mild withdrawal symptoms on sudden discontinuation after prolonged treatment with high doses. Occasional hormonal effects (impotence, decreased libido, and estrogenic effects) may be observed. Atropine-like effects may be more pronounced (e.g. paralytic ileus) in susceptible patients and in those using anticholinergic agents (including antiparkinsonism drugs).
Outpatient Adult Dosage: Initially, 75 mg. daily, increased, if necessary, to 150 or 200 mg. Maintenance dosage may be lower, 50 to 150 mg. daily, if possible.
Geriatric and Adolescent Dosage: Initially, 30 or 40 mg. daily, which may be increased according to response and tolerance. It is usually unnecessary to exceed 100 mg. daily.
A lag in therapeutic response, lasting from a few days to a few weeks, should be expected. When dosage recommendations are already being followed, increasing the dosage does not normally shorten this latency period and may increase the incidence of adverse reactions.
Availability: Round tablets of 25 and 50 mg.; triangular tablets of 10 mg. for geriatric and adolescent use; and ampuls, each containing 25 mg. in 2 cc. for I.M. administration.
(B)R-46-850-C

For complete details, please refer to the full Prescribing Information.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

TO-6757

(Continued from Page 362)

cally and functionally disabled.

7. Coordination and expansion of services for the Orthopedic and functionally disabled.

8. Establishment of a Cooperative program to care for persons disabled by accident and injury.

Thirty-two members of the committee, including 18 doctors and 14 laymen, number eight orthopedists, two internists, a psychiatrist, a neurologist, a pediatrician and a sociologist among them.

Medical Aspects Of Sports Conference To Be Held In Miami

The Tenth National Conference on the Medical Aspects of Sports will be held at the Hotel Deauville, Miami Beach, Fla., Dec. 1. Sponsored by the AMA's Committee on the Medical Aspects of Sports, the meeting is held annually in conjunction with the AMA Clinical Convention.

The conference will include forums on the management of knee injuries, back problems, and problems related to vision in sports. Other sessions will be devoted to a series of other sports problems warranting increased clinical attention—"cauliflower ear," pulled muscles, facial injuries, and communicable disease. Discussion sessions will be devoted to the controversial issues affecting participation of young athletes, special concerns in sports and health and safety considerations in the conduct of aquatic activities.

Payton Jordan, head coach of the 1968 U. S. Olympic Track and Field Team, will discuss "The Olympics in Retrospect" at the luncheon session.

All interested physicians should write the Committee on the Medical Aspects of Sports, AMA, 535 North Dearborn Street, Chicago, Illinois 60610, for additional information.



THE BETTMANN ARCHIVES

Just one tablet at bedtime • Prevents painful night leg cramps • Permits restful sleep

How many of your patients stamp their feet at night and lose sleep because of painful leg cramps? Unless prompted, they usually fail to report this distressing condition and suffer needlessly.

One tablet of QUINAMM at bedtime usually controls distressing night cramps and permits restful sleep with the initial dose.

Prescribing information—Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Side Effects/Precautions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON MERRELL INC.
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Nuclear Medicine . . . the Decades After Alamagordo

About 20 years ago, a scientist working at the then super-secret Los Alamos, N. M., Manhattan Project laboratory dropped a hint to a non-scientist friend in Santa Fe.

"Tonight," the scientist said, "go to the top of Sandia Mountain and keep looking south. Before the night is over you'll know what we've been doing down here."

The friend took the tip, and in the early morning hours of July 16, 1945, he saw the sun rise in the south. The Atomic Age had arrived in a ball of flame on the floor of the New Mexico desert.

In the decades since, nuclear science has helped achieve historic advances in all sciences, including biology and medicine.

For example, scientists who learned that deoxyribonucleic acid (DNA) is the storehouse of genetic information probably would have been stymied very early in their work if radioisotope "tracer" chemicals had not been available.

At least one Los Alamos scientist has predicted that the biological sciences, with the help of nuclear technology, will produce advances in the next 20 years that will dwarf the atomic bomb. In fact, he believes that advances in biology in the next 10 years may equal or surpass those made in physics in the 1935-45 decade.

Nuclear medicine today has a span reaching from clinical radiology to molecular biology. And most of its growth has taken place in less than a quarter century—since the first sustained nuclear chain reaction was achieved in a secret nuclear pile under the spectator stands at the University of Chicago's Stagg Field.

The very beginning dates back just 70 years. The German physicist Wilhelm Roentgen discovered X-rays in 1895. Natural radioactivity was discovered in uranium by a French physicist Henri Becquerel, in 1896. Within a few years both X-rays and naturally radioactive elements, especially radium, were being used in medicine.

At first radiation was used without an understanding of its origins. Not until the 1930s did atomic theory and experimental data permit scientists to form a concept of the atom as a nucleus of protons and neutrons surrounded by shells of orbiting electrons. And once scientists began to understand the atom, they began to suspect they could split it.

With cyclotrons and later other particle accelerators, physicists bombarded atoms with other atoms or atomic particles—protons, neutrons, and electrons—hoping to learn more about the atomic nucleus.

In the process they discovered that sometimes certain species of atoms can "capture" a neutron. By capturing a neutron an atom can become a heavier isotope of the same species. Other isotopes can be produced by interaction of certain atoms with high-energy protons, deuterons, and alpha particles. Quite often, however, these man-made isotopes are unstable and decay to a stable atom of the same or another element by emitting energy in the form of radiation. In other words, they are radioactive—"radioisotopes."

Radioisotopes are chemically identical to stable isotopes of their same species. In the chemistry laboratory, for instance, radioactive phosphorus is indistinguishable from nonradioactive phosphorus unless the chemist brings a radiation detector into play.

Living organisms, including the human body, are equally unable to differentiate radioactive from nonradioactive isotopes. Radioisotopes introduced into the body behave chemically the same as their non-radioactive cousins.

As early as 1923, scientists had recognized

(Continued on Page 372)

A science feature article prepared by the Communications Division, American Medical Association.



"All Registered Nurses are Alike"

It stands to reason. They all go through the same training; they all have to pass the same tests; they all have to measure up to the same standards. Therefore, all registered nurses are alike.

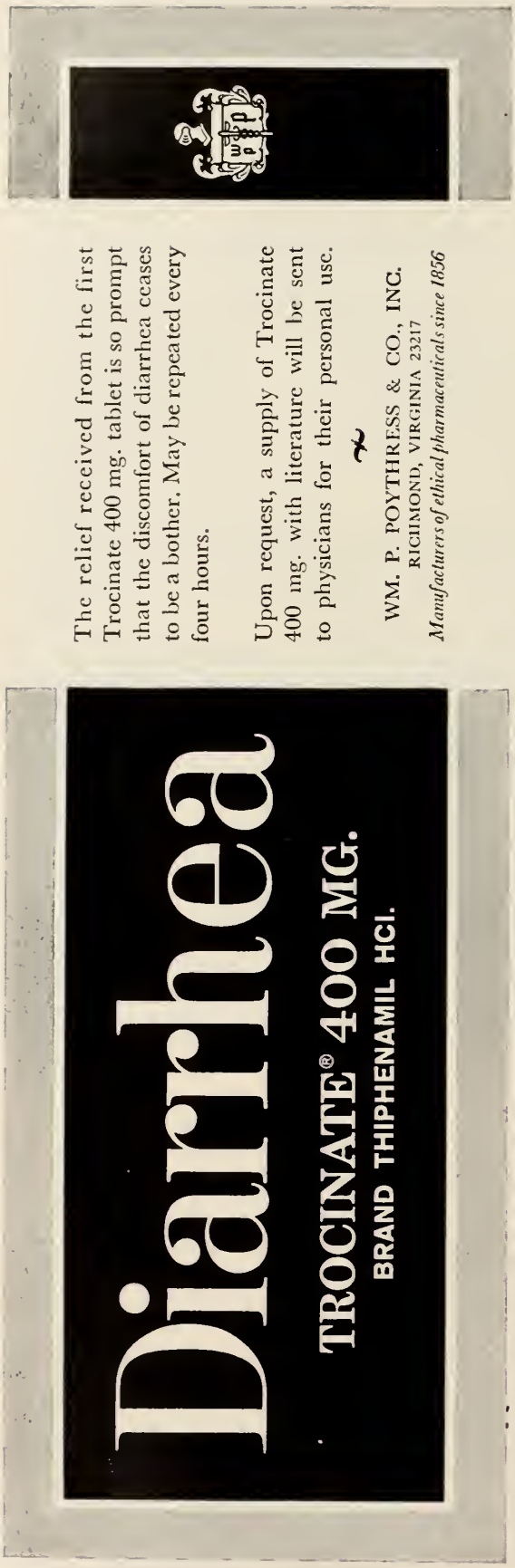
That's nonsense, of course. But it's no more nonsensical than what some people say about aspirin. Namely: since all aspirin is at least supposed to come up to certain required standards, then all aspirin tablets must be alike.

Bayer's standards are far more demanding. In fact, there are at least *nine specific differences* involving purity, potency and speed of tablet disintegration. These Bayer® standards result in significant product benefits including gentleness to the stomach, and product stability that enables Bayer tablets to *stay* strong and gentle until they are taken.

So next time you hear someone say that all aspirin tablets are alike, you can say, with confidence, that it just isn't so.

You might also say that all registered nurses aren't alike, either.





(Continued from Page 370)

the potential of natural radioisotopes in biological research. By the time artificially created radioisotopes arrived, scientists knew they had a powerful tool for investigation.

When introduced into the body, an energetic radioisotope is detectable outside the body. Thus, the radioactivity serves as a beacon that can be followed as the radioisotope moves through the metabolic pathways. A doctor reading such signals may be able to determine whether the body is handling this particular chemical in a normal or abnormal fashion. Indeed, development of isotopically-tagged chemicals has permitted physicians to investigate many bodily functions that could not otherwise be studied.

The therapeutic possibilities of the radioisotope haven't been overlooked, either. By the late 1930s medical investigators knew that specific elements or compounds required by the human body could be produced in radioactive forms and introduced into patients. If the compound is tissue- or organ-specific, as iodine is for thyroid tissue, physicians theorized it should carry ionizing radiation directly to the spot to be irradiated. Their theory was correct, but so far the therapeutic uses of radioisotopes are far outnumbered by the diagnostic uses.

Radioisotopes were actually used in patients in the late 1930s and early 1940s. But cyclotron isotopes were rare and expensive. Large-scale use of isotopes had to await their large-scale production. Since large-scale isotope production requires the large supply of neutrons that is found only in nuclear reactors, medicine had to wait for its radioisotopes until 1946 when reactors were released from full-time work on the atomic bomb.

Radioactive isotopes are used experimentally in a number of ways. Some of these are:

(1) Administration of radioisotopes loosely combined with complex organic compounds. Zinc-65 combined with insulin to

(Continued on Page 376)



AMA

22ND CLINICAL CONVENTION

MIAMI BEACH

DECEMBER 1-4, 1968 · CONVENTION HALL

. . . the American "Riviera." Where glittering luxury hotels tower above glamorous Collins Avenue; and medicine, sea and sunshine mix in a delightful subtropical setting.

Register now, and be on hand for the world's largest winter medical meeting—the AMA's 22nd Clinical Convention. At this midwinter "summer" session in medicine there will be Three Postgraduate Courses: Fluid and Electrolyte Balance, Diabetes, and Hyperthyroidism in the Elderly Patient • 17 Scientific Sessions • Breakfast Roundtable Conferences • Color Television • and Medical Motion Pictures. The modern, air-conditioned Convention Hall will house hundreds of scientific and industrial exhibits to show you the very latest in equipment, services and drugs.

Plan now to join your colleagues in Miami Beach. Be sure to look for the complete scientific program, plus forms for advance registration and hotel accommodations in the October 21st issue of JAMA.



pinworms in this school?

possibly, because hygienic measures alone, however meticulous, may not prevent the spread of pinworm infections which are estimated to occur in from ⅓ to more than ½ of all American children from every social level

REMINDER: Because pinworm infections spread easily and quickly in families, schools, and institutions, multiple infections among primary groups seem to be the rule rather than the exception. For successful management, it is desirable to check all exposed members of the family or play group. The *single-dose efficacy* of POVAN makes therapy entirely practical, convenient, and economical.

INDICATION: Pinworm infection.

PRECAUTIONS: Tablets should be swallowed whole to avoid staining teeth. Pyrvinium pamoate will stain most materials. Stools may be colored red.

ADVERSE REACTIONS: Nausea, vomiting, cramping, and diarrhea have been reported.

POVAN is available in suspension or tablet form. The pleasant-tasting, strawberry-flavored suspension contains the pamoate equivalent of 10 mg. of pyrvinium base per cc., in 2-oz. bottles. The sugar-coated tablets each contain the pamoate equivalent of 50 mg. of pyrvinium base, bottles of 25.

When examination reveals pinworm infection—an increasing number of physicians favor treatment with a single, well-tolerated dose of—

Povan®
(pyrvinium pamoate)

PARKE, DAVIS & COMPANY, DETROIT, MICHIGAN 48232

PARKE-DAVIS

44768

(Continued from Page 372)

determine the time and place of insulin's action.

(2) Administration of radioisotopes in simple chemical form to plants or animals which use those particular chemicals in synthesizing more complex compounds. Administration of carbon-14-labeled carbon dioxide to plants, with the aim of extracting carbon-14-labeled compounds.

(3) Neutron irradiation of experimental animals to cause certain minerals within the body to become radioactive and thereby permit scientists to study their function. Neutron irradiation of rats and rabbits to study the paths and functions of trace minerals in mammals.

Experimental nuclear medicine is not tied only to the radioisotope, however.

The thirty-fifth generation of an irradiated mouse colony is enjoying life in a laboratory building at Los Alamos. In return for free room and board in comfortable cages the mice furnish information which is helping Los Alamos scientists determine the long-term effects of radiation upon a mammalian population. The possibility of genetic damage to humanity from fallout and other radiation sources, a major concern of the Atomic Age, prompted the investigation.

"For the seven years we've maintained the colony, we have irradiated males with 200 roentgens of cobalt-60 gamma radiation before they are allowed to breed," explains Dr. Wright Langham, group leader of the Los Alamos Scientific Laboratory Biological and Medical Research Group. "We've looking for any genetic weakening of the mouse strain from a constant, high level of irradiation. The results to date fail to show any weakening effect on this mouse population.

"The most outstanding effect we have seen is that the irradiated population has fewer mice per litter than a non-irradiated control population. But the number of litters per female has increased in the irradiated mice, so we get the same number of mice from the irradiated line as we get from the control line.

"We have not been able to produce the genetic death of a mammalian population. When radiation stress at this level is brought to bear on a population, it apparently shifts its equilibrium. We think now that irradiation cannot cause the genetic death of a mammalian population, unless the level of radiation is high enough to sterilize."

Meanwhile, a number of tamarins—small, teddy-bear-cute primates housed at the Oak Ridge Institute of Nuclear Studies, are being used in transplantation studies by Dr. Nazareth Gengozian and associates. Dr. Gengozian says that tamarins, natives of the equatorial forests of Colombia, Ecuador, Peru and Bolivia, are probably the cuddliest-looking of all laboratory animals. But their appearance does not deceive animal handlers who have seen tamarins bite through an armored glove.

It is not the cuteness or vicious temper of the tamarin that biologists find intriguing, however. They are interested in the fact that tamarin females almost always bear twins, and the twins apparently are always fraternal rather than identical. Even more uniquely, an exchange of blood-forming tissue takes place between the twins while they are still in the mother's uterus. The "foreign" tissue received by each twin is not destroyed by their respective immunological systems, so each twin is born a chimera, with blood-forming tissues of two genetic types. The chimera of biology, an individual with two types of genetic tissue, is named for the chimera of mythology—an animal made up of incongruous parts.

The discovery of natural chimerism is a windfall for Dr. Gengozian, who has worked for several years on the problem of transplanting bone marrow and other tissues in human beings. The chief problem of transplantation is overcoming the immune barrier —getting the transplanted tissue to "stick"

(Continued on Page 380)



"Man's best friend" in wintertime diarrheas

In winter "flu" and viral gastroenteritis, Donnagel (4 oz. size!) can bring aid and comfort to sufferers from both diarrhea and its discomforts because it contains kaolin and pectin plus belladonna alkaloids (as in Donnatal®). Donnagel treats the whole diarrhea problem. Available on your prescription or recommendation. A. H. Robins Company, Richmond, Va. 23220

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All the Robitussins contain glyceryl guaiacolate, the outstanding expectorant agent that greatly increases the output of lower respiratory tract fluid. Increased RTF volume exerts a demulcent effect on the tracheo-bronchial mucosa, promotes ciliary action, and makes thick, inspissated mucus less viscid and easier to raise.

For coughs of colds and "flu"
ROBITUSSIN®
Each 5 cc. contains:
Glyceryl guaiacolate . . . . . 100 mg.
Alcohol, 3.5%

For unproductive allergic coughs
ROBITUSSIN® A-C
Each 5 cc. contains:
Glyceryl guaiacolate . . . . . 100 mg.
Pheniramine maleate . . . . . 7.5 mg.
Codeine phosphate . . . . . 10.0 mg.
(warning: may be habit forming)
Alcohol, 3.5%

Non-narcotic for 6-8 hour cough control
ROBITUSSIN®-DM
Each 5 cc. contains:
Glyceryl guaiacolate . . . . . 100 mg.
Dextromethorphan hydrobromide . 15.0 mg.
Alcohol, 1.4%

Clears sinuses and nasal stuffiness as it relieves cough
ROBITUSSIN®-PE
Each 5 cc. contains:
Glyceryl guaiacolate . . . . . 100 mg.
Phenylephrine hydrochloride . . . 10.0 mg.
Alcohol, 1.4%

	ROBITUSSIN	ROBITUSSIN A-C	ROBITUSSIN-DM	ROBITUSSIN-PE
EXPECTORANT	●	●	●	●
DEMULCENT	●	●	●	●
COUGH SUPPRESSANT		●	●	
ANTIHISTAMINE		●		
LONG-ACTING (6-8 HOURS)			●	
NASAL, SINUS DECONGESTANT				●

PHOTO BY VICTOR HAND

A. H. Robins Company, Richmond, Va. 23220

A·H·ROBINS

(Continued from Page 376)

in the face of the host body's anti-foreign tissue immune reaction. Dr. Gengozian can now ask: If chimerism can exist in nature, can we induce artificial chimerism in animals and human beings? If artificial chimirism could be induced—a bit of pure speculation, Dr. Gengozian stresses—physicians might find it possible to:

(1) Replace bone marrow in patients whose own marrow has been destroyed by irradiation—either accidentally or therapeutically for leukemia or other blood diseases.

(2) Better understand the nature of immune rejection.

So far, Dr. Gengozian and his associates can only detect male-female tamarin chimerism with accuracy. One of their next projects is to learn how to establish male-male chimerism. Also planned are experiments designed to answer such basic questions as: Can tamarin tolerance for foreign red cells be broken down with ionizing radiation? Are skin grafts effective in indicating tolerance in tamarin chimeras? How stable is the chimerism with age? What are the possible degrees of chimerism? With regard to the latter question, the Oak Ridge scientists have already found one tamarin male whose body was estimated to contain 90 per cent female white blood cells.

Aside from its use as an investigative tool, nuclear scientists are also studying radiation in terms of its direct effects on life.

Of all the words invented to explain Atomic Age phenomena, probably none has been used and misused more than "fallout"—a term coined in 1945 to describe the radioactive debris that settles to earth after nuclear explosions.

Before the U. S.-Soviet treaty banning nuclear tests in the atmosphere, arguments concerning fallout raged in newspapers almost

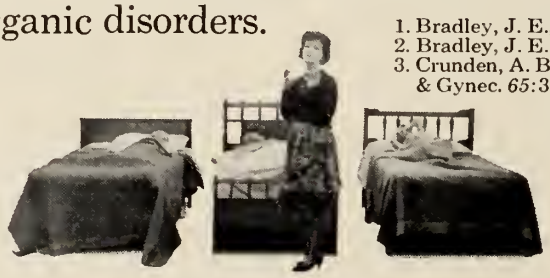
(Continued on Page 384)



Togetherness....

...can be rough when epidemics of nausea and vomiting strike a family. Emetrol offers prompt, safe relief. It is free from toxicity[1] or side effects[2,3] and will not mask symptoms of serious organic disorders.

1. Bradley, J. E., *et al.*: J. Pediat. *38*:41 (Jan.) 1951.
2. Bradley, J. E.: Mod. Med. *20*:71 (Oct. 15) 1952.
3. Crunden, A. B., Jr., and Davis, W. A.: Am. J. Obst. & Gynec. *65*:311 (Feb.) 1953.



ROHRER

WILLIAM H. RORER, INC.
Fort Washington, Pa.

Emetrol®
phosphorated carbohydrate solution
emesis control

When it's more than a bad cold



your patient can feel better while he's getting better

Achrocidin®

Tetracycline HCl—Antihistamine—Analgesic Compound

Each tablet contains: ACHROMYCIN® Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Caffeine 30 mg.; Salicylamide 150 mg.; Chlorothen citrate 25 mg.

In tetracycline-sensitive bacterial infection complicating respiratory allergy, ACHROCIDIN brings the treatment together in a single prescription—prompt relief of headache and congestion together with effective control of the organisms frequently responsible for complications leading to prolonged disability in the susceptible patient.

For children and elderly patients you may prefer caffeine-free ACHROCIDIN Syrup. Each 5 cc contains: ACHROMYCIN (Tetracycline) equivalent to Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Salicylamide 150 mg.; Ascorbic Acid (C) 25 mg.; Pyrilamine Maleate 15 mg.

Contraindications: Hypersensitivity to any component.

Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.

Precautions: Drowsiness, anorexia, slight gastric distress can occur. In excessive drowsiness, consider longer dosage intervals. Persons on full dosage should not operate vehicles. Nonsusceptible organisms may overgrow; treat superinfection appropriately. Treat beta-hemolytic streptococcal infections at least 10 days to help prevent rheumatic fever or acute glomerulonephritis. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity* reactions—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

Upon adverse reaction, stop medication and treat appropriately.

Lederle

348-8



"Upper respiratory infection! I thought everything was a 'virus' these days?"

Some U.R.I. patients are more miserable than others.

That's why we make Novahistine® in two different tablet formulations.

And let you control the dosage.

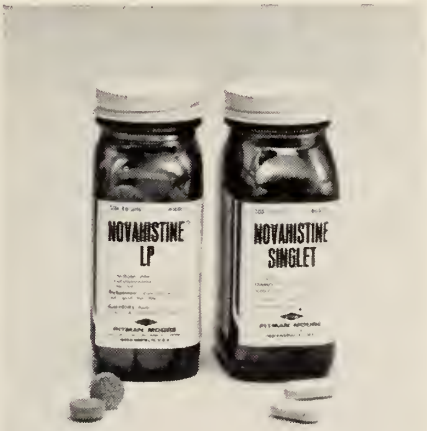
With Novahistine LP tablets and Novahistine Singlet™ tablets you have the range and flexibility of decongestant dosage that lets you prescribe for the needs of the individual patient.

Novahistine LP tablets are most useful for relief of nasal congestion in patients without pain or fever.

Novahistine Singlet tablets, which provide analgesic-antipyretic effect, as well as decongestant action, are indicated for upper respiratory infections accompanied by pain, aches and fever.

Whether you prescribe Novahistine LP or Novahistine Singlet, a total daily dose of 3 or 4 tablets will usually provide effective, continuous relief.

Use cautiously in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.



Each Novahistine LP tablet contains phenylephrine hydrochloride, 25 mg.; and chlorpheniramine maleate, 4 mg.

Each Novahistine Singlet tablet contains phenylephrine hydrochloride, 40 mg.; chlorpheniramine maleate, 8 mg.; and acetaminophen, 500 mg.

Dow **PITMAN-MOORE** DIVISION OF THE DOW CHEMICAL COMPANY, INDIANAPOLIS

(Continued from Page 380)

daily. The official U. S. government position, as expressed by the AEC, was that fallout from nuclear tests could be dangerous but that consistently dangerous levels of fallout from nuclear bomb testing in the atmosphere had not yet been reached. Some nongovernmental authorities challenged this position in varying degrees, the most extreme saying that every nuclear test produced radioactive materials which weakened the human race through disease and genetic damage. Thus, one task of nuclear medicine has been to attempt to determine how much fallout is a dangerous amount, and to set safety standards for the public.

Of the approximately 200 different radioactive species produced in fission processes, only a few are known to be a possible hazard to man. The hazard represented by a radionuclide depends upon: (1) the amount produced; (2) its radioactive half-life; (3) the efficiency with which it is transferred through the food chain to human diet—that is, whether it appears in possibly harmful amounts on plants consumed directly by man, or on plants consumed by food animals; and, (4) its metabolism in the body of food animals and in the body of man—that is, whether it appears in possibly harmful amounts in meat and milk consumed by man, and whether it concentrates in some area of the human body where it can potentially cause harm.

Some of fallout radionuclides with the most potential for hazard:

Iodine-131—eight-day half-life; concentrates in milk of cattle that eat contaminated feed; concentrates in thyroid of man.

Strontium-90 and Strontium-89—half-lives of 28 years and 51 days respectively; present in cow's milk and leafy plant foods; concentrates in bone of man and animals, although strontium concentration in bone is minimized if enough calcium is available in the body.

Cesium-137—30-year half-life; appears in milk, meat, flour, cereals, vegetables and fruits; behaves in biological systems much the same as potassium but is removed from the body fairly rapidly.

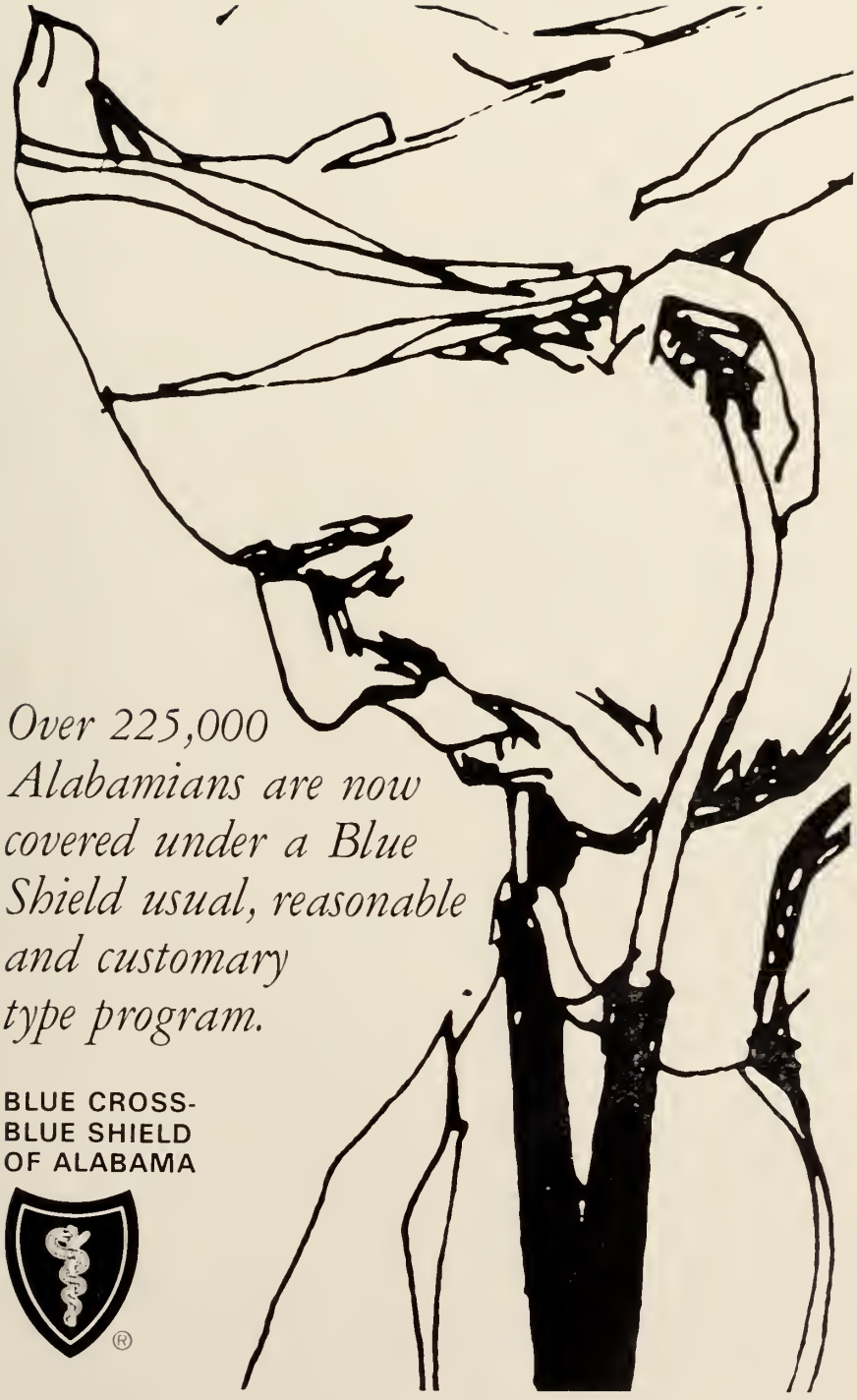
Carbon-14—5,800-year half-life; appears in most biological systems; since carbon is basic to all organic forms of life on earth, it is taken up by all; the amount of carbon-14 produced by nuclear explosions is small, but remains active for many centuries.

Others—cerium-144, zinc-65, iron-55, iron-59, and cobalt-60 are all concentrated by organisms in the human food chain, but their hazard is not considered great.

Scientists are still gathering data to determine the effects of fallout ingestion on human beings. The final results may not be in for many more years, but the AEC feels that no significant ill effects will be revealed in the population as a whole.

Industrial nuclear hygiene is only as old as the Atomic Age. But, 2,600 health physicists and specialists guard the well-being of the thousands of workers in the atomic and nuclear industries, according to Dr. Harry Schulte, group leader of the Los Alamos industrial hygiene group. By way of contrast—and pointing up the lengths to which nuclear safety has been taken—about 2,000 industrial health specialists work in all other American industries combined, helping to safeguard hundreds of thousands of workers. It is a proud point with nuclear health physicists that there has never been a case of plutonium or uranium poisoning among plant or laboratory personnel.

"The power reactor is the answer to the environmental health specialist's prayer," says Dr. Schulte. "It just sits there quietly producing power and doing almost nothing to pollute the countryside. No smoke, no ash, no smell. In fact, more radioactive material gets into the atmosphere in the fly ash from a coal-burning power station than you'll ever see escaping from a reactor facility."


Over 225,000 Alabamians are now covered under a Blue Shield usual, reasonable and customary type program.
BLUE CROSS-
BLUE SHIELD
OF ALABAMA
®

PHYSICIAN PLACEMENT SERVICE IN ALABAMA

The Physician Placement Service of the Medical Association of the State of Alabama is designed to assist both physicians and communities. MASA members having knowledge of practice opportunities or wishing to relocate their own practices are urged to communicate with the Placement Service. For further information: write Mr. Emmett Wyatt, Executive Assistant, Medical Association of the State of Alabama, 19 South Jackson Street, Montgomery, Alabama 36104, or Telephone 263-6441.

Locations Wanted

General Practice—

Age 27; Louisiana State University 1967; seeking group or associate practice. Available August 1968. LW-335

Age 38; University of Oklahoma, 1955; seeking associate, institutional or industrial practice; in town of 10,000 plus population; interest in surgery. LW-336

Age 28; University of Tennessee, 1965; available November 1968. LW-337

Age 28; Medical College of Alabama 1966; seeking practice in town of less than 14,000 population to fulfill scholarship requirements. Available 1968. LW-338

Age 52; University of Chicago 1950; seeking group, industrial, institutional or student health position. LW-339

Age 56; Georgetown University 1938; seeking solo, group or associate practice, with general surgery. Available July 1968. LW-340

Internal Medicine—

Age 34; Hahnemann Medical College 1959; Board eligible, National Board; seeking solo, group, or associate practice. Available immediately. LW-342

Age 34; University of Tennessee, 1958; American Board Certified, seeking group, industrial, or institutional practice. Available Spring 1968. LW-343

Age 32; University of Louisville 1965; seeking associate or group practice in city of approximately 50,000 population. Available July 1969. LW-343/1

Age 34; University of Mississippi 1960; Board eligible; seeking location in southern section of Alabama in city of 15,000 plus population. LW-343-2

University of Mississippi 1963; seeking group practice in city of 20,000-40,000 population. LW-343-3

Neurology—

Age 31; Harvard 1962; Board eligible; National Board; seeking solo, group or associate practice. Available July 1969. LW-344

Age 30; Medical College of Alabama 1962; Board eligible; National Board; seeking solo, group, associate or institutional practice. Available January 1969. LW-345

Obstetrics-Gynecology—

Age 35; Vanderbilt University 1950; Board eligible; Available July 1968. LW-346

Age 37; University of Virginia 1959; Board certified; seeking group or associate practice. Available September 1968. LW-347

Age 34; University of Missouri 1959; Board certified; seeking group, industrial, associate or institutional practice. Available July 1968. LW-348

Age 36; Medical College of Alabama 1957; Board eligible; seeking group or associate practice. Available immediately. LW-348-A

Radiology—

Age 31; S. U. N. Y. College of Medicine, 1961; Board eligible; seeking solo, group, or associate practice. LW-350

Age 41; Cornell Univ. Medical School, 1953; Board certified; seeking group, or associate practice. Available immediately. LW-351

Age 51; Univ. of Texas Med. Branch, 1942; Board certified; seeking solo, group, or associate practice. LW-352

Surgery—

Age 33; University of Missouri, 1961; seeking group or associate practice. Available January 1969. LW-353

Age 38; Emory University, 1956; Board eligible; seeking group, associate, or institutional practice. Available July 1968. LW-354

Age 37; Faculty of Medicine, Manitoba, 1957; Board certified; seeking associate or institutional practice. Available July 1968. LW-355

Age 34; Board eligible; University of Santo Tomas, 1961; seeking group or associate practice. Available July 1968. LW-356

Age 35; Board eligible; Univ. of Santo Tomas, 1956; seeking solo, group, industrial or associate or institutional practice with general practice. Available immediately. LW-357

• • •

Physicians Wanted

General Practitioners—

Opportunity for group practice in town of 10,000 population in north Alabama. PW-211

Physician wanted to join 39 year old Medical College of Alabama graduate in a well established general practice in West Central Alabama town. Salary initially followed soon by full partnership. PW-211-1

Opportunity in community of 5,000 population in trade area of 30,000 population located in northeast Alabama where at present time there are only two active full time general practitioners. Modern offices or clinic facilities available. 48-bed accredited hospital and 52-bed skilled nursing home adjoining the hospital. Cities of approximately 75,000 population located within 25 miles distance. Agricultural and expanding industrial area. Numerous churches and schools. Country club and golf course being developed and water sports and out-

PHYSICIANS WANTED

(Continued)

door activities offer recreational advantages. PW-211-2

For town in South Alabama with 20,000 trade area, within 40 miles of Gulf beaches and large city. Excellent hunting and fishing. Numerous industries offering stable employment for area. Furnished office available rent free. Hospital presently engaged in complete remodeling and expansion. PW-212

For town of 4,500 population in trade area of 10,000 to 15,000 with annual payroll of 4½ million dollars, located in north central Alabama. Within 75 and 85 miles respectively of two metropolitan areas with combined population of 2 million. Hospital privileges available in modern 30-bed hospital. A modern 40-bed extended care facility adjoins hospital. Excellent churches, schools and shopping areas. In the center of the best hunting, fishing and recreational area in the state. PW-212/1

Physician wanted to join well established partnership in Northwest Alabama city of 15,000 population. Two accredited hospitals, junior college, schools, churches, recreational activities. No obstetrics or surgery. New office building. PW-212/2

For city of approximately 15,000 population in north Alabama, with trade area of approximately 45,000 population. Hospital with over 100 beds, and expansion planned for next year. Nursing homes in the area. Industrial growth and agricultural region. Several churches and schools. Golf course, civic and fraternal organizations. PW-212/3

Unusual opportunity for two general practitioners with military obligations satisfied at a modern fifty bed facility located 15 minutes drive from largest metropolitan center in north-central Alabama. Construction of a new two-story office building is scheduled to begin soon. PW-213

Opportunity in rapidly expanding community of 10,000-12,000 population adjacent to metropolitan center in north Alabama. Office space free for six months and equipment available. Staff privileges at nearby hospitals. PW-214

For town of 3,600 population in trade area of 5,000-7,000 within 100 miles of two large cities and the Gulf Coast. 50-bed hospital located in the town. Office space available. Agricultural and expanding industrial area. Several churches and two schools. Recreational activities in the town as well as nearby—golf course, hunting and fishing. PW-215

For town of approximately 1,000 population in North-central Alabama in trade area of 12,000 population. 100-bed hospital in adjoining city. PW-216

For town of 12,500 population in trade area of 50,000 located in South Alabama. Nearest large city with population of 145,000 is 80 miles. One of the physicians died recently. Two hospitals with 140 beds. Numerous small industries; several churches and schools. Recreational activities include water sports and golf course. PW-217

For town of approximately 1,000 population in population center of 10,000 located in Southwest Alabama within 90 miles of the Gulf coast. City owned clinic is offered rent free and fully equipped. Hospitals are located in two nearby towns within 25 miles. This is principally an agricultural region, but there are military installations nearby. Numerous civic clubs, community concert series, and a country club offer recreational activities. PW-218

For town with 1,000 population in trade area of 5,000 Southeast Alabama. Nearest large city with population of 50,000 is 55 miles. New clinic available rent free. No physicians in the town. Hospitals in surrounding town within 30 miles. Several churches and schools. PW-219

Opportunity in city of 5,000 population located in Northeast Alabama in trade area of approximately 10,000 population. Office space available. One physician died recently. Hospital and nursing home in the city. PW-220

For town of 1,000 plus population in west-central Alabama in trade area of 20,000. Clinic available. Nearest city of approximately 70,000 population is located a distance of 17 miles. Farming, cattle, timber, and manufacturing plants are principal resources of the area. Churches, schools, and recreational advantages. PW-221

For solo practice in town of approximately 17,000 population located in east central Alabama. 48-bed general hospital. Arrangements available for office space. Excellent recreational advantages which include hunting, fishing and water sports. City owned airport. Numerous civic clubs. Excellent schools and churches. Expanding industrial and agricultural area. PW-222

Opportunity for one or more doctors in rapidly expanding eastern suburb of Birmingham. Attractive brick building consisting of 10 rooms and adjacent parking facilities. PW-223

Opportunity for general practitioner to join a five-man group, practicing as a partnership. Each man in the group is either specialized or semi-specialized. The practice is physically located within a 70-bed hospital. Willing to pay qualified person $36,000 for the first year, with possible partnership status in one year. Would consider a physician for locum tenens for three to six months at $2,000 per month. PW-224

Opportunity in centrally located town in North Alabama in trade area of 10,000-15,000 population. The only doctor is retiring. Housing and office space readily available. Churches and schools. Recreational advantages of nearby lakes. PW-225

Surgeon—

Opportunity for a Board eligible or Certified surgeon to practice in city of over 78,000 population in north Alabama. Equipment available. PW-226

Special Openings

Opportunity for physician interested in joining a progressive public health tuberculosis control program working in Birmingham, Jefferson County. Provide outpatient medical services and some administrative duties. Fringe benefits and salary open. PW-230



Summation:
In addition to its primary indications for duodenal and gastric ulcer, Robinul Forte (glycopyrrolate) is indicated for other G-I conditions that may benefit from anticholinergic therapy. Robinul-PH Forte (glycopyrrolate 2 mg. with phenobarbital) is indicated when these situations are complicated by mild anxiety and tension.

Contraindications: Glaucoma, urinary bladder neck obstruction, pyloric obstruction, stenosis with significant gastric retention, prostatic hypertrophy, duodenal obstruction, cardiospasm (megaesophagus), and achalasia of the esophagus, and in the case of Robinul-PH Forte, sensitivity to phenobarbital.

Precautions: Administer with caution in the presence of incipient glaucoma.

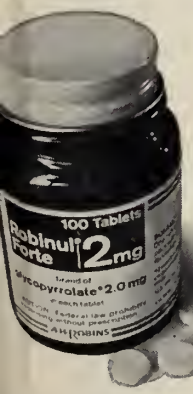
Adverse Reactions: Dryness of the mouth, blurred vision, urinary difficulties, and constipation are rarely troublesome and may generally be controlled by reduction of dosage. Other side effects associated with the use of anticholinergic drugs include tachycardia, palpitation, dilatation of the pupil, increased ocular tension, weakness, nausea, vomiting, headache, dizziness, drowsiness, and rash.

Dosage: Should be adjusted according to individual patient response. Average and maximum recommended dose is 1 tablet three times a day; in the a.m., early p.m., and at bedtime. See product literature for full prescribing information.

Supply: Robinul (glycopyrrolate 1 mg.): Robinul Forte (glycopyrrolate 2 mg.): Robinul-PH (glycopyrrolate 1 mg.) with phenobarbital 16.2 mg. (Warning: may be habit forming); Robinul-PH Forte (glycopyrrolate 2 mg.) with phenobarbital 16.2 mg. (Warning: may be habit forming), in bottles of 100 and 500 tablets. A. H. Robins Company, Richmond, Va. 23220.

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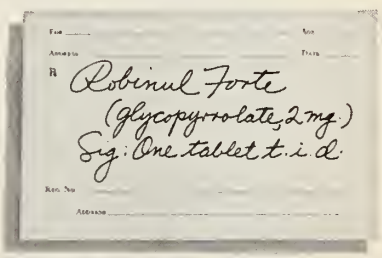
In peptic ulcer therapy, won't you give Robinul® Forte a Fair Trial?
(glycopyrrolate)



Six years ago the A. H. Robins Company introduced glycopyrrolate, a unique anticholinergic agent described in the prescribing literature as more closely approaching the ideal compound for controlling gastric hyperacidity and hypermotility of the G-I tract. Although glycopyrrolate (Robinul Forte) found good acceptance among numerous physicians, many others just didn't seem to want to give it a try, probably because the anticholinergic they were already using was giving acceptable results.

However, we believe you'll agree there's always room for a better anticholinergic. This is why we're asking you to give Robinul Forte a fair trial. Robinul Forte exerts a highly specific antisecretory action and marked inhibitory effect on intestinal tone. We're convinced you'll agree that this is indeed an outstanding drug when you observe its outstanding suppression of ulcer symptoms. Furthermore, it is unique in that it reduces intestinal tone, yet has little or no effect on peristalsis. In addition, the incidence of the more bothersome peripheral side effects is low.

No longer does the physician have to look for extreme dry mouth as the measure of his anticholinergic's effectiveness. The only way we can demonstrate to you firsthand the efficacy of glycopyrrolate (Robinul Forte) is for you to try it in your practice. That's why we're asking you to give it a Fair Trial. How can you give it a Fair Trial? You do it this way:



First: When you see your very next ulcer patient, write him a script as shown.

Next: Wait 10 days or until your patient comes in for his next appointment and get his "verdict" as to how he feels. Examine all the evidence and make your evaluation of his condition.



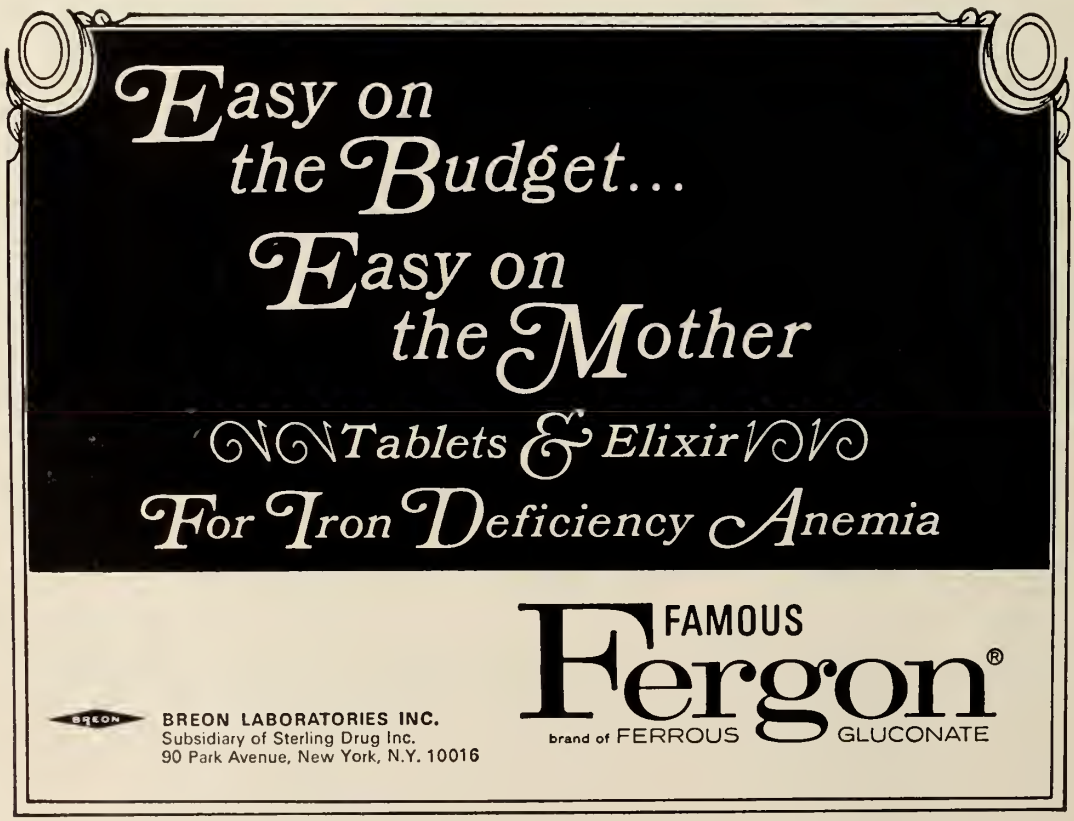
Finally: Render **your** verdict. If it's "significant improvement and marked relief of symptoms," then we believe you'll agree that Robinul Forte has proved its worth, and we rest our case. If not, consider our case for Robinul Forte closed. That's a Fair Trial, Doctor, and it's all we ask.

Robinul® Forte
(glycopyrrolate, 2 mg.)

The summation is an important part of every case. You'll find ours on the preceding page, Doctor.

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Before prescribing, see complete prescribing information in SK&F literature or *PDR*.

Contraindications: Glaucoma, prostatic hypertrophy, stenosing peptic ulcer, pyloroduodenal or bladder neck obstruction.

Precautions: Use cautiously in the presence of hypertension, hyperthyroidism, coronary artery disease; warn vehicle or machine operators of possible drowsiness.

Usage in Pregnancy: Use in pregnancy, nursing mothers and women who might bear children only when potential benefits have been weighed against possible hazards.

Note: The iodine in isopropamide iodide may alter PBI test results and will suppress I^{131} uptake; discontinue 'Ornade' one week before these tests.

Adverse Reactions: Drowsiness; excessive dryness of nose, throat or mouth; nervousness; insomnia. Other known possible adverse reactions of the individual ingredients: nausea, vomiting, diarrhea, rash, dizziness, fatigue, tightness of chest, abdominal pain, irritability, tachycardia, headache, incoordination, tremor, difficulty in urination. Thrombocytopenia, leukopenia and convulsions have been reported.

Supplied: Bottles of 50 capsules.



a stuffy nose is no laughing matter

Ornade® Trademark

Each capsule contains 8 mg. of Teldrin® (brand of chlorpheniramine maleate), 50 mg. of phenylpropanolamine hydrochloride, and 2.5 mg. of isopropamide, as the iodide.

Spansule® Capsules

brand of sustained release capsules

each one can give him all-day or all-night relief of nasal congestion

SK&F Smith Kline & French, Laboratories



...because psychic tension may not stop at night

The calming action of Valium (diazepam) helps counteract psychic tension and reduce overreaction to stresses during the day. Often the t.i.d. dosage schedule is enough to prevent build-up of tenseness that may interfere with sleep at night.

However, when psychic tension does contribute to sleeplessness, Valium can be especially useful. A tablet at bedtime, added to the daytime t.i.d. dosage, can help your patient be ready for bed *and* for sleep.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or wit suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclu ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopi hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurre speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such acute hyperexcited states, anxiety, hallucir tions, increased muscle spasticity, insomn rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Valium®
(diazepam)

ROCHE
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THE JOURNAL

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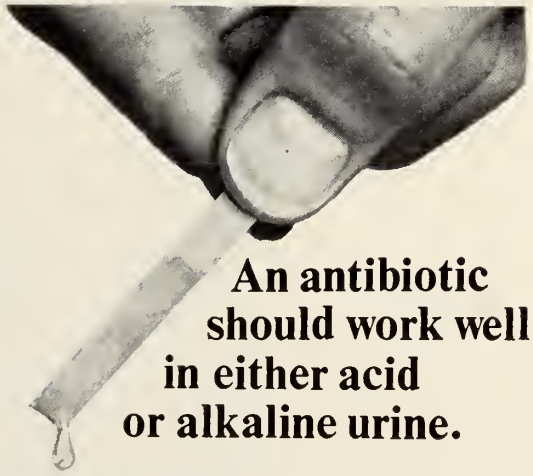
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Side Effects: Gastrointestinal system – anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin – maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney – rise in BUN, apparently dose-related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions–urticaria, angioneurotic edema, anaphylaxis. Teeth – dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

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President's Page



E. L. McCafferty, Jr.

In my initial remarks to the Association last April I stated that my main objectives were two fold: One, service to the doctors; Two, unity in our society toward reaching its full potential.

I realize that in one year no one will accomplish these goals, but I hope that the foundations will be laid and in the years to come succeeding officers and trustees of your Association will find the programs that have been instituted by the Board of Trustees this year worthy, and will continue to develop and expand them to their ultimate capacity.

I believe we have a stronger organization here to work for you and a staff who serves you cheerfully and with devotion because they believe in the fundamental dedication of the medical profession.

As our society becomes more complicated and laws and guidelines proliferate, the need for legal advice becomes more frequent, both on an individual and collective basis. As many of you already know, Mr. Reginald Hamner has been appointed to the position of Director of Legislative—Legal Affairs for the Medical Association of the State of Alabama. We feel most fortunate in having Mr. Hamner with us. We believe that he will round out the central headquarters staff that will be capable of rendering to the members of the Medical Association invaluable service.

Since one of the principal aims of the Medical Association of the State of Alabama is to offer a complete service to its membership, our only interest is to promote your interest and to protect the health and the welfare of the people in this state.

To have a member of our staff who is a lawyer, a graduate of the University of Alabama, offers a unique advantage for each of us. For the individual, Mr. Hamner will be available to answer legal questions that frequently arise in our daily practice. Although most of you have your own lawyer, at times he may not be familiar with the medical questions that so frequently arise and for which we need a quick answer. Mr. Hamner will be our authority on medico-legal problems and available to you all the time.

For the county medical society and its officers Mr. Hamner will, of course, be of great importance and I would suppose that it will be in this area that he will find his most frequent requests for assistance. Mr. Hamner is available to all the members as an individual or county society, either by letter or telephone, whenever you feel you have a legal problem or need his assistance.

It is also anticipated that Mr. Hamner will visit the county societies on invitation and act as the liaison between the county societies and State Association. It is my feeling that

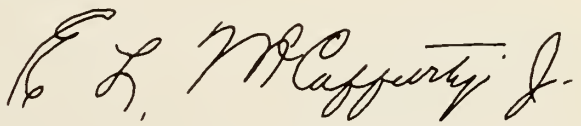
through closer relationship we can do much to strengthen the unity of our Association and to speak on a county and state level with a clearer voice.

We have recently initiated a program to interest medical students, interns and residents in organized medicine. I hope that it will be successful. As always the final result will depend to a great degree on the loyalty, the interest that you as individual physicians reflect toward these young people in organized medicine, and your interest in them as individuals who will in time achieve a place in your community.

I urge each of you to invite medical students of your area to attend your meetings when they are at home, participate in them so that they will know the doctor is what he seems and not what he is sometimes pictured by groups outside of the profession who may have other axes to grind.

We have been happy to have attend the Board of Trustees' meetings Dr. T. Albert Farmer, Mr. William Hogan (representing the Student American Medical Association), and Mr. William C. Walley (president of the student body of the Medical School at the University of Alabama), and to have them participate in our proceedings. From them we have gained new aspirations, and working with them we hope to evolve a closer relationship with the students, interns, and residents.

Pursuing this endeavor I have appointed Dr. James Donald to be chairman of a subcommittee on the Physicians' Advisory Board to the Medical College of Alabama. I believe this can be a fine program in the years to come. As in other programs, I urge your individual efforts and interest in accomplishing these goals.



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AUXILIARY PLEDGE

"I pledge my loyalty and devotion to the Woman's Auxiliary to the American Medical Association. I will support its activities, protect its reputation and ever sustain its high ideals."

Since writing my last President's Page, I have had the opportunity of visiting in three Auxiliaries for their first meetings, Blount, Houston and Cullman Counties. As I speak at these meetings, I discuss three keys, which are essential to a successful Auxiliary: the key of Enthusiasm, the key of Good Programs, and the key of Worthy Projects. While in Mexico, I purchased three lovely brass keys, and was told they can be used for decorative purposes in the home, or as bottle openers. I have found a third use for them, as I take them to Auxiliary meetings, and urge members to use them for opening many doors of opportunity, service and rewarding experiences during this year.

The first District meeting was held at Point Clear on September 20, and was a good meeting, which was well attended. In October and November, the other District meetings will be held, and will, I am sure, be informative and inspirational.

Ruth Johnson and I attended the Fall Conference in Chicago September 29 through October 2, and the Regional Workshop, with several of our State Chairmen, in New Orleans, October 10 and 11.

One of our emphases this year is Legislation, and we feel that it is especially important during this election year. We are urging the Legislation chairmen in the local Auxiliaries to keep its importance before their members, and to stress the necessity of being informed and active.

We are also stressing ALAPAC and AMPAC, and urging all members to join, and to encourage their husbands to do so. We feel that as we participate actively in these



Mrs. Robert K. Wilson, Sr.

areas, that we are truly serving as an Auxiliary to the Medical Association, and if there is anything further that we can do, please let us know.

Perhaps some of you will recognize your wife in the following:

What is an Auxiliary Member?

What makes her such a valued member of her community? What qualities does

She possess, to make her dedication evident?

Well, it may be her understanding, but it is

(Continued on Page 403)

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Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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Use with caution in pregnant women and nursing mothers since the drug may cross the placental barrier and appear in cord blood and since thiazides may appear in breast milk. The drug may result in fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult. When used in women of childbearing age, balance benefits of drug against possible hazards to fetus.

Precautions: Antihypertensive therapy with this drug should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents, other potent antihypertensive drugs or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. Because of the possibility of progression of renal damage, periodic determination of the BUN is indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated.

Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, the drug should be discontinued and potassium supplements given, provided the patient does not have marked oliguria.

Take special care in cirrhosis or severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended.

Adverse Reactions: Nausea, gastric irritation, vomiting, anorexia, constipation and cramping, dizziness, weakness, restlessness, hyperglycemia, glycosuria, hyperuricemia, headache, muscle cramps, orthostatic hypotension, which may be potentiated when chlorthalidone is combined with barbiturates, narcotics or alcohol, aplastic anemia, leukopenia, thrombocytopenia, agranulocytosis, impotence, dysuria, transient myopia, skin rashes urticaria, purpura, necrotizing angiitis acute gout, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Other reactions reported with this class of compounds include: jaundice, xanthopsia, paresthesia, and photosensitization.

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(Continued from Page 396)

her tolerance, compassion, and serenity, too. It is her dignity and vibrant warmth,

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Troubled times, and replacing it with a friendly handclasp across the

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She is poised and gentle, but does not lose tenacity of purpose.

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She is reliant, tender, valiant.

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Reflecting the glow of inner tranquility.
She is the personification of femininity,
But she can drive a school bus, paint a fence,
Darn a sock, or preside at a silver tea service.

She has a sense of humor. She displays her calm and confidence;

She runs for public office; gives parties for orphans,

Serves as a volunteer hospital aide and precinct committeewoman.

She trims Christmas trees, and little girls' bangs!

She is a den mother and a Sunday School teacher;

She is a cook, nurse, friend and neighbor.
She has a nebulous quality that enables her to listen to music lessons,

Television and barking dogs—all at the same time.

She can advise, lead, confide and soothe.

She cares what happens in the world.

She is able to surmount the problems that face her;

She is constantly working and praying for peace.

But she is more than the sum and substance of things you see and hear.

She may be a sister, a cousin, an aunt, a teacher, a niece, a student,

A career woman, a grandmother, or possibly a great-grandmother,

A mother-in-law, a foster mother, a wife and mother. But most important,

She is able to recognize the symptoms of colic, measles and puppy love;

Able to soothe a troubled baby, a hungry child, a bewildered teen-ager,

A work-weary mate and an aging parent, while aiding a displaced person or

A victim of aggression through service to her Auxiliary.

She is the proud possessor of a great, common, human heart

And like you and I, she is honored to be called an Auxiliary member.

We may have missiles in the skies above,
But far mor eimportant is the fact that we have Auxiliary members

With their feet on the ground.

Louise M. Wilson

(Mrs. Robert K. Wilson, Sr.)
President WAMASA

(The above was written by Mrs. Leo Curtis, who served as Junior Director of the General Federation of Women's Clubs, 1958-60. It was written as a description of the Federated clubwoman, but can certainly be applied to the members of the Auxiliary to the Medical Association of the State of Alabama.)

Alabama Department of Public Health

Laboratory Expands Screening Procedures

By Joyce T. Murphree

Four new tests for metabolic disorders of infants are being added to screening procedures performed in the central laboratory of the Alabama Department of Public Health. They will be performed in conjunction with the established testing procedure for phenylketonuria (PKU).

Dr. Thomas S. Hosty, director of the Bureau of Laboratories, said tests for homocystinuria, maple syrup urine disease, tyrosinosis, and galactosemia are being added on an experimental basis. The continuation of the tests will be determined by findings during the trial period.

PKU testing was begun by the Bureau of Laboratories in 1964, and it became compulsory in 1965 by an act of the legislature. The law requires that each newborn child be tested and places the responsibility for initiating testing on the attending physician or administrator of the hospital in which the child is born.

A sample of the infant's blood is collected on filter paper and sent to a laboratory for analysis. Except for a few PKU tests being performed by a private laboratory in Birmingham, the PKU testing program is conducted exclusively in the central laboratory of the state health department.

Blood specimens submitted for PKU screening will be used in making the four new tests. The five diseases are similar in that they are metabolic, inherited disorders characterized by abnormal enzymes.

PKU does not directly limit the life span, but if untreated often results in mental retardation. It is caused by failure to properly metabolize phenylalanine, which is present in most protein foods. Brain development is retarded as phenylalanine accumulates in the blood. Mental retardation can be avoided if the infant is placed on a low-phenylalanine diet soon after birth. Since the testing program was begun in Alabama, 12 cases have been detected. Seven were infants discovered early enough to diet.

Homocystinuria also causes mental retardation. Symptoms of the disease are vascular accidents, dislocated lenses, reduced joint mobility, failure to thrive, and peculiar gait. First discovered in 1962, the condition is not rare.[1] The laboratory test is designed to detect methionine, the forerunner to homocystinuria. Treatment for the condition is a low-methionine diet.

Maple syrup urine disease is characterized by a urinary odor similar to maple syrup. The affected infant appears normal at birth, but after a few days he develops symptoms of urinary odor, vomiting, muscular hypertonicity, and spasms. Severe mental and motor retardation result, and unless treated, early death is expected. A synthetic diet low in leucine, isoleucine, and valine is prescribed. Unless testing is accomplished within the first few days of life, affected infants will die before a diagnosis is made. Therefore, although the disease is described as rare, the

Reprint from "Alabama's Health," September, 1968.

1. Dr. Mary L. Efron and Dr. Mary G. Ampola, "The Amino Acidurias," Pediatric Clinics Of North America (W. B. Saunders Co., 1967), Vol. 14, No. 4.

true incidence will not be known until effective testing can be performed soon after birth.

Only a few cases of tyrosinosis have been treated, and the incidence is not definitely known. Symptoms include renal tubular defects, progressive cirrhosis, vitamin D-resistant rickets, and in some cases, mental retardation. Most untreated cases die of cirrhosis of the liver within the first decade of life. A diet low in tyrosine and phenylalanine has resulted in improvement in the few treated cases.[2]

Galactosemia, which occurs at a rate of about one in 30,000 births, manifests itself shortly after birth. Usually normal at birth, the child develops an intolerance to milk. Galactose is a component of lactose in milk, and the infant is unable to convert it to glucose. Vomiting and diarrhea are primary symptoms, followed by weight loss, dehydration, and growth failure. As the disease progresses, jaundice and abdominal distention appear, and death may occur. In cases where there is some tolerance to milk, cataracts and mental retardation may develop at approximately one month of age. Cirrhosis of the liver may follow. Dramatic improvement is noted when galactose is removed from the diet.

With the exception of galactosemia, the presence of the metabolic diseases is determined by a bacterial assay test. Galactosemia is detected by a fluorescent reaction.

To expedite plating of specimens for the bacterial assay tests, the Bureau of Laboratories purchased a multiple punch machine a few months ago. James L. Holston, Jr., microbiologist in the metabolic division, went to Los Angeles for two weeks and worked with the machine's inventor to learn its operation and maintenance. There are only three other such machines in the United States and one in Germany.

The machine simultaneously punches four discs from blood specimens on filter paper and places them on plates coated with a culture medium. Plating time is reduced by about 50 per cent with the machine.

Because of the reduction in plating time made possible by the multiple punch machine and the established mechanism of submitting specimens, the four new tests can be performed with little additional expense, Dr. Hosty said.

Mrs. Ruby Atkins, who heads the serology, cytology, and metabolic divisions, said the PKU tests are widely used now, and maple syrup urine disease tests are being performed routinely by public health laboratories in a few states. To her knowledge, however, the other tests are not a part of the routine screening procedures of any public health laboratory. In fact, the tests are so new that inhibitors, reagents, and controls are not available commercially.

The primary objective of the project is determination of the incidence of the diseases among the Alabama population, but results could have far-reaching significance. Knowledge may be gained that will lead to a reduction in the alarming number of infant deaths in this state, or perhaps a clue to mysterious infant deaths—often called crib deaths—may be found.

Based on a five-year average of infant deaths, Alabama ranks fifth highest. Figures supplied by the Bureau of Vital Statistics give Alabama's infant death rate for the 1961-65 period as 31.2 per 1,000 population. Only Mississippi, Alaska, the District of Columbia, and South Carolina had higher rates.

Deaths of children under the age of one year totaled 1,727 in 1967. Of this number 190 deaths were attributed to unknown or ill-defined causes, and listed causes such as aspiration, asphyxiation, strangulation, or suffocation may, in some instances, be the result of an underlying disease.

Undoubtedly, the pilot project will be watched with interest in Alabama and across the nation.

2. Ibid.

BUREAU OF PREVENTABLE DISEASES

W. H. Y. Smith, M. D., Director

Current Morbidity Statistics

1968

	July	Aug.	*E. E. Aug.
Tuberculosis	116	173	125
Syphilis	109	66	148
Gonorrhea	526	620	387
Chancroid	0	6	1
Typhoid fever	0	0	0
Undulant fever	0	0	1
Amebic dysentery	0	0	4
Scarlet fever & strep. throat	255	363	92
Diphtheria	0	0	0
Whooping cough	18	8	4
Meningitis	5	12	6
Tularemia	0	0	0
Tetanus	0	1	1
Poliomyelitis	1	0	4
Encephalitis	0	0	0
Smallpox	0	0	0
Measles	11	9	19
Chickenpox	4	0	2
Mumps	28	14	17
Infectious hepatitis	15	16	39
Typhus fever	0	0	0
Malaria	1	4	0
Cancer	1,028	1,146	739
Pellagra	0	0	0
Rheumatic fever	9	6	15
Rheumatic heart	13	11	22
Influenza	5	20	18
Pneumonia	165	194	142
Rabies—Human cases	0	0	0
Pos. animal heads	2	1	0

As reported by physicians and including deaths not reported as cases.

*E. E.—The estimated expectancy represents the median incidence of the past nine years.

BUREAU OF PREVENTABLE DISEASES

W. H. Y. Smith, M. D., Director

Current Morbidity Statistics

1968

	August.	Sept.	*E. E. Sept.
Tuberculosis	173	92	111
Syphilis	66	60	120
Gonorrhea	620	422	375
Chancroid	6	6	2
Typhoid fever	0	2	1
Undulant fever	0	1	0
Amebic dysentery	0	0	4
Scarlet fever & strep. throat	363	371	66
Diphtheria	0	10	2
Whooping cough	8	21	14
Meningitis	12	5	6
Tularemia	0	0	0
Tetanus	1	1	1
Poliomyelitis	1	0	3
Encephalitis	0	0	0
Smallpox	0	0	0
Measles	9	0	12
Chickenpox	0	2	2
Mumps	14	8	15
Infectious hepatitis	16	40	39
Typhus fever	0	0	0
Malaria	4	3	0
Cancer	1,146	824	613
Pellagra	0	0	0
Rheumatic fever	6	7	13
Rheumatic heart	11	8	24
Influenza	20	17	25
Pneumonia	194	146	126
Rabies—Human cases	0	0	0
Pos. animal heads	1	0	0

As reported by physicians and including deaths not reported as cases.

*E. E.—The estimated expectancy represents the median incidence of the past nine years.

BUREAU OF VITAL STATISTICS

PROVISIONAL BIRTH AND DEATH STATISTICS AND COMPARATIVE DATA

Ralph W. Roberts, M. S., Director

JULY 1968

Live Births / Deaths / Causes of Death	Number Registered During July 1968			Rates* (Annual Basis)		
	Total	White	Non-White	1968	1967	1966
Live Births	5,515	3,632	1,883	18.1	18.3	19.0
Deaths	2,698	1,807	891	8.8	8.6	8.9
Fetal Deaths	106	50	56	18.9	17.7	22.0
Infant Deaths—						
under one month	107	56	51	19.4	21.1	21.3
under one year	139	64	75	25.2	27.4	26.9
Maternal Deaths					5.3	3.4
Causes of Death						
Tuberculosis, 001-019	21	9	12	6.9	5.3	8.7
Syphilis, 020-029	3	2	1	1.0	1.0	0.7
Dysentery, 045-048	1		1	0.3		
Diphtheria, 055						
Whooping cough, 056						
Meningococcal infections, 057	1		1	0.3		
Poliomyelitis, 080-081						
Measles, 085						
Malignant neoplasms, 140-205	394	300	94	129.1	121.3	111.0
Diabetes mellitus, 260	62	33	29	20.3	13.9	17.4
Pellagra, 281					0.3	
Vascular lesions of central nervous system, 330-334	379	228	151	124.2	110.4	125.0
Rheumatic fever, 400-402	1	1		0.3		
Diseases of the heart, 410-443	852	637	215	279.1	277.3	294.2
Hypertension with heart disease, 440-443	86	40	46	28.2	39.3	44.1
Diseases of the arteries, 450-456	68	42	26	22.3	28.8	16.4
Influenza, 480-483	1		1	0.3		0.7
Pneumonia, all forms, 490-493	46	29	17	15.1	17.8	20.1
Bronchitis, 500-502	5	4	1	1.6	1.7	2.7
Appendicitis, 530-553	3	1	2	1.0	1.0	1.0
Intestinal obstruction and hernia, 560, 561, 570	12	8	4	3.9	3.6	3.7
Gastro-enteritis and colitis, under 2, 571.0, 764	7	1	6	2.3	3.0	1.7
Cirrhosis of liver, 581	17	12	5	5.6	5.6	6.4
Diseases of pregnancy and childbirth, 640-689					5.3	3.4
Congenital malformation, 750-759	34	25	9	6.3	4.0	4.6
Immaturity at birth, 774-776	26	9	17	4.7	4.0	6.7
Accidents, total, 800-962	224	152	72	73.4	68.1	74.2
Motor vehicle accidents, 810-835, 960	118	81	37	38.7	34.4	34.8
All other defined causes	422	258	164	138.2	137.5	134.4
Ill-defined and unknown causes, 780-793, 795	119	56	63	39.0	44.0	48.5

*Rates: Birth and death—per 1,000 population
Infant deaths—per 1,000 live births
Fetal deaths—per 1,000 deliveries
Maternal deaths—per 10,000 deliveries
Deaths from specified causes—per 100,000 population

The muscle relaxant that works before you write a prescription

Relieve painful skeletal muscle spasm in your office in minutes with a single 2 cc. injection of NORFLEX. Then, for sustained relief, write a prescription for NORFLEX tablets, 1 tablet b.i.d.

CONTRAINDICATIONS: Due to its anticholinergic action, NORFLEX should not be used in patients with glaucoma, pyloric or duodenal obstruction, stenosing peptic ulcer, prostatic hypertrophy or obstruction at the bladder neck, cardiospasm (megaesophagus) and myasthenia gravis. Use with caution in patients with tachycardia. Do not use propoxyphene (Darvon®) concurrently.

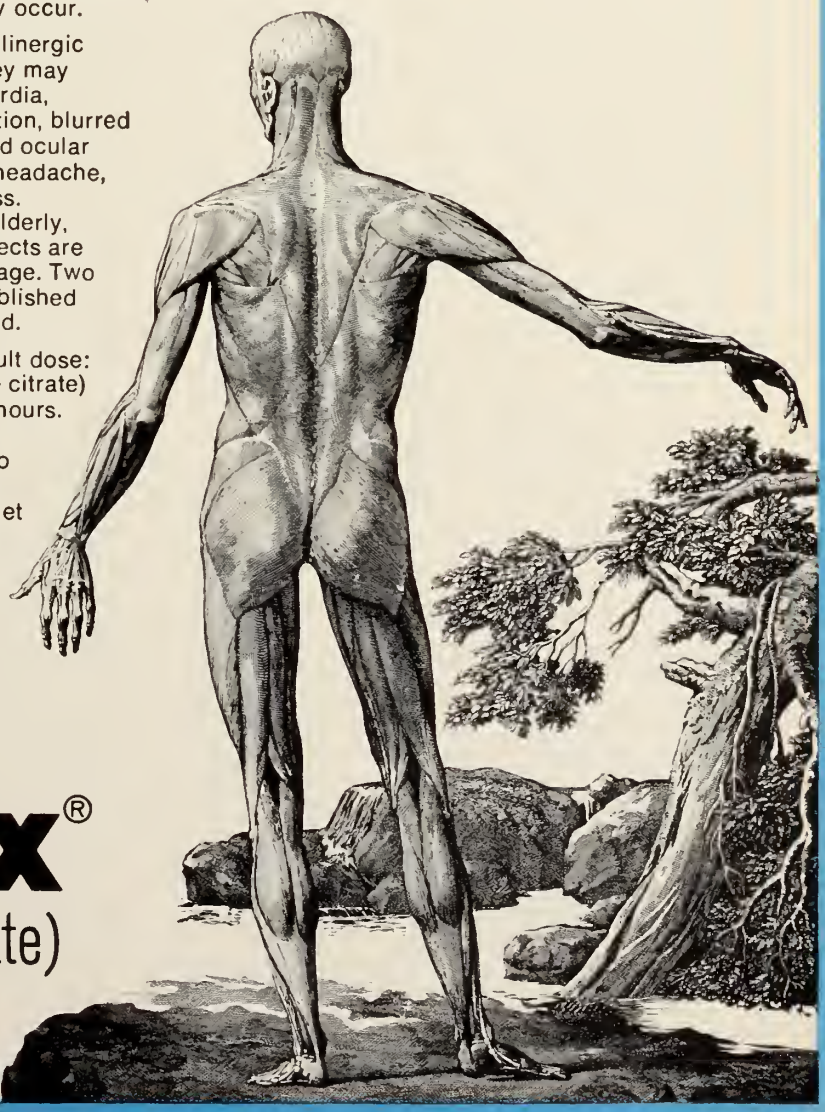
WARNING: Transient lightheadedness or dizziness following NORFLEX-INJECTABLE may occur.

SIDE EFFECTS: Due mainly to anticholinergic action and usually at high dosage. They may include dryness of the mouth, tachycardia, palpitation, urinary hesitancy or retention, blurred vision, dilatation of the pupil, increased ocular tension, weakness, nausea, vomiting, headache, dizziness, constipation, and drowsiness. Infrequently, mental confusion in the elderly, urticaria or other dermatoses. Side effects are usually eliminated by reduction in dosage. Two cases of aplastic anemia, with no established causal relationship, have been reported.

DOSAGE: **INJECTABLE** — Average adult dose: one ampul, 2 cc. (60 mg. orphenadrine citrate) I.M. or I.V. May be repeated every 12 hours. Relief may be maintained with one NORFLEX tablet b.i.d. **TABLETS** — Two tablets per day for adults, one in the morning, one in the evening. Each tablet contains 100 mg. orphenadrine citrate.

For full information, see Package Insert or P.D.R.

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Norflex®
(orphenadrine citrate)



Do Faint Warnings Encourage Juvenile Use of Drugs?

As certainly as faint praise was once considered damning, so might tepid warnings on marihuana, LSD, amphetamines, and narcotics from the National Institute of Mental Health be considered encouragement of their use among the young.

Four new flyers prepared by NIMH "separate accurate scientific information from rumors and half-truths about drugs," says a sanctimonious publicity release, adding "They explain the known dangers, but are frank to point out areas where more data is needed to establish firm conclusions," according to Dr. Stanley F. Yolles, NIMH Director.

"Risks" for young users of the popularized "psychedelic drugs," but without "scare warnings that cannot be backed by scientific evidence." For instance, students are warned that the use of marihuana is a "law violation" that might embarrass them, but also carefully presented are "the difficulties researchers face in assessing long-term physical and emotional effects of marihuana."

Dr. Yolles said: "In today's drug-oriented culture where Americans are taking drugs in greater variety and greater and greater number than ever before, the youth are in urgent need of straightforward facts about those drugs that certain cults and fads have made over-appealing.

"This series of flyers," he added, "explains as honestly and frankly as possible why we are alarmed at the growing unsupervised use of drugs."

Widely used "pep pills" and "goof balls," and other narcotic drugs, including amphetamines and barbiturates, are discussed in the pamphlets, in question-and-answer form, including a description of the drug's effect, recent research findings, and outlines of current efforts to solve the problems of drug abuse.

Each pamphlet was reviewed in advance, not only by physicians and psychologists, but by "teachers, experts in drug abuse education, and many young people," and they are especially "designed for wide distribution among youth groups and schools."

The Bulletin (of the Tulane University Medical Faculty) summarized a survey of narcotic addiction thus: "This population of New Orleans addicts was found to be similar to those in other areas. Almost three-fourths of them were members of a minority group. Less than 20 per cent were females. The majority of male addicts used *other* drugs before 'graduating' to heroin. (Almost 50 per cent started using marijuana and 30 per cent first used barbiturates.)

"As the demographic maps indicate, heroin use is directly associated geographically with the illegal use of other drugs such as barbiturates, amphetamines, and marijuana."

The article offered "a statistical composite of the typical New Orleans addict who obtains drugs illegally:" A 26-year-old Negro male who prefers heroin to other drugs and would first have begun using marijuana in his mid-teens. He would live in a slum area and would resort to illegal means to obtain the money to support his habit of three $5

capsules a day. He would already have been arrested for a non-drug offense before finally being arrested in the street for possession of heroin while in the central city area.

Would this statistical composite of the typical New Orleans addict be dismissed by NIMH as a "scare warning that cannot be backed by scientific evidence?"

A sober look at these drugs is taken in a series of 2- to 4-page assessments published by AMA's Department of Health Education, Division of Health Service, each priced at 15c a copy, or at a graduated reduction in bulk. Titles are *Amphetamines, Barbiturates, L S D, Marihuana,* and *Glue Sniffing.*

Meantime, Richard Nixon became the first of the three presidential candidates to recognize the problem when he said in a California speech:

"Let us begin to face facts. Narcotics are the modern curse of American youth. Just like the plagues and epidemics of former years, these drugs are decimating a generation of Americans." He pledged his administration to fight it by tripling customs agents to tighten border security against drugs, set up commissions with other nations to stem the flow, strengthen federal rehabilitation programs, begin a review of smuggling laws, and bring together law officials to discuss ways of ending the drug traffic.

Pathological Liar Pesters Alabama, Tennessee Hospitals

A pesky pathological liar is loose in the state, and having exhausted her welcome in Huntsville has gone elsewhere to pursue a pattern of behavior that has confounded and exhausted the staff of Huntsville's City Hospital.

Short, obese and in her late 30's, known to have been a prostitute and drug addict, she goes under different aliases, including Marcella Dixon and Carol Walton. Her true name is known, but without a police record to support the entry, the name is withheld here for obvious reasons.

"She represents," writes Dr. William H. Goodson, Jr., of Huntsville, in a letter to The Journal of the Medical Association, "a variant of the Munchausen syndrome, and she also seeks narcotics. . .

"Her abdomen is covered with scars from polysurgery. She has been known to feign miscarriages (she perhaps malingered a positive pregnancy test by bringing someone else's urine into the hospital), and typhoid fever (she truly has a chronic diarrhea which has been thoroughly evaluated, and she has a positive typhoid agglutination in our hospital which may have been due to recent immunization).

"She refused to eat a balanced diet, seemed to prefer mostly sweets. The only procedure she refused to submit to was a lumbar puncture. . .

"Her psychiatric condition, best classified as sociopathic personality, is probably untreatable, and so we deemed commitment to be to no avail. She was discharged to return to her home in Nashville. It would seem advisable to confine her legally, if someone can devise the means."

She spent a month in the Huntsville hospital, and three hospitals in Tennessee's capital city—St. Thomas, Vanderbilt and Nashville Hospital—are known to have had much the same experience with her.

More . . . Or More Expanded Medical Schools?

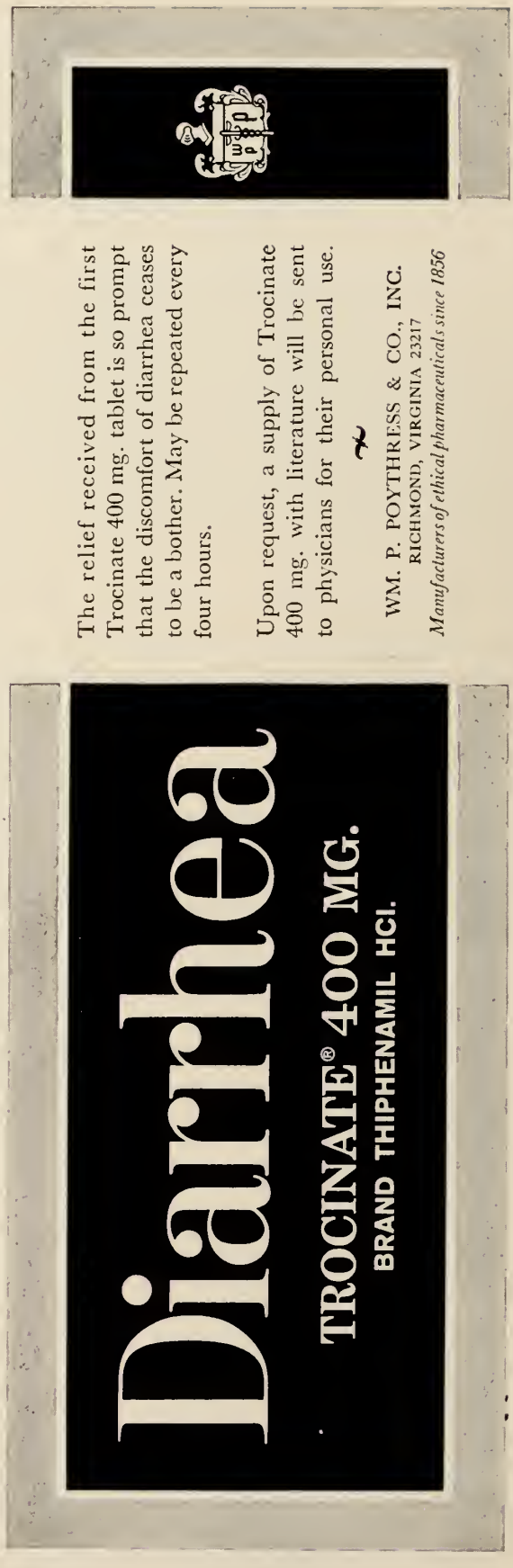
While the debate between those who want more medical schools and those who would expand present facilities continues hot, and while the numbers of graduating doctors continue to shrink, the AMA and the Association of American Medical Colleges are agreed in urging that both ways are necessary.

AMA is dedicated to "providing its maximum assistance in aiding the expansion of existing medical schools and in the creation of new institutions." It eyes the disturbing drop in graduates of medical colleges and the paralleling decline in numbers accepted for medical school as evidence of need for a change. In Pennsylvania alone there was a notable drop in graduates in 1967 from the totals of ten years ago:

"Jefferson graduated 165 in 1957, and 161 in 1967; University of Pennsylvania, 126 in 1957, and 122 in 1967; Woman's Medical College, 40 in 1957, and 37 in 1967; University of Pittsburgh 91 in 1957, and 82 in 1967."

Ironically, misinformed communications media have indicted the doctors of the nation in general and AMA in particular with discouraging an increase in the medical college output, presumably for selfish reasons. Says *PR Doctor*, an AMA magazine, on the subject: ". . . these unsubstantiated criticisms gain new mileage through repetition and they help not one iota in seeking a solution to the health manpower crisis. More likely, they may well have disheartened and deterred many a conscientious physician in his constructive thought and deed toward alleviating the problem."

The University of Alabama Medical College is probably the exception that proves the rule! Its graduate totals for 1967 were 74, up six from the total of 68 ten years before.



the antacid puzzle

In peptic ulcer:



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aluminum and magnesium hydroxides *plus* simethicone

"will it ease the pain?"

Mylanta helps relieve ulcer pain with the two most widely prescribed antacids: aluminum and magnesium hydroxides.

will it help "my gassy stomach"?

Mylanta *also* contains simethicone: for concomitant relief of G.I. gas distress.

"will this one taste O. K.?"

The *prolonged* acceptance of Mylanta was recently confirmed in 87.5% of 104 patients—after a total of 20,459 documented days of therapy.* *Danhof, I. E.: Report on file.

Composition: Each Mylanta chewable tablet or teaspoonful (5 ml.) contains: magnesium hydroxide, 200 mg.; aluminum hydroxide, dried gel, 200 mg.; simethicone, 20 mg. *Dosage:* One or two tablets (well chewed or allowed to dissolve in the mouth) or one or two teaspoonfuls to be taken between meals and at bedtime.

Stuart

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ATLAS CHEMICAL INDUSTRIES, INC.

a comprehensive hematinic



Description: Each Pulvule® contains—

Special Liver-Stomach Concentrate, Lilly (containing Intrinsic Factor)	150	mg.
Cobalamin Concentrate, N.F., equivalent to Cobalamin (The total vitamin B_{12} activity in the Special Liver-Stomach Concentrate, Lilly, and the Cobalamin Concentrate, N.F., is 15 micrograms.)	7.5	mcg.
Iron, Elemental (as Ferrous Fumarate)	110	mg.
Ascorbic Acid (Vitamin C)	75	mg.
Folic Acid	1	mg.

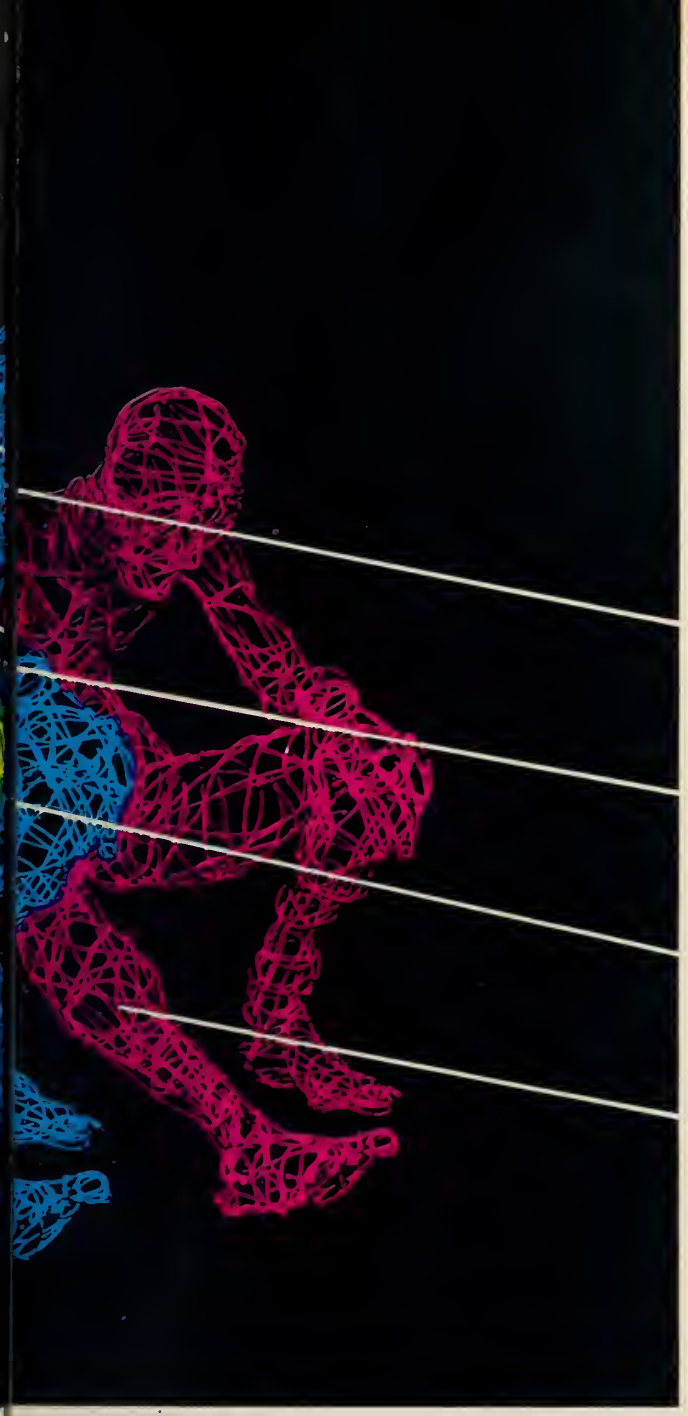
Indications: Trinsicon® (hematinic concentrate with intrinsic factor, Lilly) is a multifactor preparation effective in the treatment of anemias that respond to oral hematinics, including pernicious anemia and other megaloblastic anemias and also iron-deficiency anemia.

Contraindications: Hemochromatosis and hemosiderosis.

Precautions: Anemia is a manifestation that requires appropriate investigation to determine its cause or causes.

In pernicious anemia, the use of folic acid without adequate vitamin B_{12} therapy may result in hematologic remission but neurological progression. Adequate doses of vitamin B_{12} (parenteral or oral with potent intrinsic factor as in Trinsicon® [hematinic concentrate with intrinsic factor, Lilly]) usually prevent, halt, or improve the neurological changes.

As with all preparations containing intrinsic factor, resistance may develop in some cases of pernicious anemia to the potentiation of absorption of physiological doses of vitamin B_{12}. If resistance occurs, parenteral therapy, or oral therapy with so-called massive doses of vitamin B_{12}, may be necessary. No single regimen fits all cases, and the status of the patient observed in follow-up is the final criterion for adequacy of therapy. Periodi



You can treat combined deficiencies with

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Vitamin B_{12} plus intrinsic factor (15 mcg. B_{12} activity)—helps provide adequate levels of this important vitamin.

Folic acid (1 mg.)—treats nutritional macrocytic anemias and/or malabsorption syndromes.

Ascorbic acid (75 mg.)—augments the conversion of folic acid to its active form and helps iron absorption.

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clinical and laboratory studies are considered essential and are recommended.

Adverse Reactions: In rare instances, iron in therapeutic doses produces gastro-intestinal reactions, such as diarrhea or constipation. Reducing the dose and administering it with meals will minimize these effects.

In extremely rare instances, skin rash suggesting allergy has followed oral administration of liver-stomach material. Instances of apparent allergic sensitization have also been reported after oral administration of folic acid.

Dosage: One Pulvule twice a day. (Two Pulvules daily produce a standard response in the average uncomplicated case of pernicious anemia.)

How Supplied: Pulvules Trinsicon® (hematinic concentrate with intrinsic factor, Lilly), in bottles of 60 and 500. [032568]

Additional information available to physicians upon request.

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Lilly



"The inconvenience of a cold"

For a cold, NTz® Nasal Spray provides rapid relief of nasal symptoms. Relief starts with the first spray which opens the inferior part of the common meatus. A second spray, a few minutes later, will shrink the turbinates to help provide sinus drainage and ventilation. Dosage may be repeated every three or four hours as needed, for temporary relief of symptoms. NTz is well tolerated but overdosage should be avoided.

As a sinusitis deterrent, NTz Nasal Spray can be used to keep the nasal passages open during a cold to help prevent development of acute sinusitis—or to help prevent the acute condition from becoming chronic.

Supplied: NTz Nasal Spray, plastic squeeze bottles of 20 ml.; NTz Nasal Solution, bottles of 30 ml. (1 fl. oz.) with dropper.

NTz is more than a simple vasoconstrictor. It contains

Neo-Synephrine® (brand of phenylephrine) HCl 0.5 per cent, the major component, virtually synonymous with fast, efficient but gentle nasal vasoconstriction.

Thenfadil® (brand of thenyldiamine) HCl 0.1 per cent, topical antihistamine for reduction of rhinorrhea, sneezing or itching. It combats the allergic reactions that may occur in colds or sinusitis.

Zephiran® (brand of benzalkonium, as chloride, refined) 1:5000, antiseptic preservative and wetting agent to promote penetration and spread of the formula.



Winthrop Laboratories, New York, N.Y. 10016 Winthrop

Are Insurance Limitations Crowding Hospitals?

Can it be that out-patient limitations are helping to crowd the nation's hospitals with patients who could be adequately treated in the doctor's office? How many hospital admissions would be avoided if subscribers of Blue Cross-Blue Shield had comprehensive benefits covering the services of physicians outside the hospital?

Seeking the answers, two groups of subscribers have been chosen in a single Kansas county. One *experimental* group of 10,000 will be given comprehensive benefits for services in the physician's office. Another *control* group of 10,000 subscribers will be similar in every respect to the experimental group, except they will not have the out-patient benefits.

At the end of a sufficient period of time (between six months and a year) the hospital utilization of the experimental group will be compared to the utilization of the control group.

Could it be that out-patient limitations are helping to crowd the hospitals as certainly as unemployment insurance and welfare are idling elements of the nation's labor?

Calendar of Annual Meetings

Medical Association of the State of Alabama

1969, April 24-26, Carriage Inn, Huntsville

1970, April 30-May 2, Mobile

1971, April 22-24, Birmingham

1972, April 20-22, Montgomery

1973, April 18-21, Mobile

Private Medicine at Crossroads?

To collaborate or not to collaborate is a question confronting the medical profession everywhere in the United States, and there seems to be no clearcut answer on which all sides agree.

David Kasanof, associate editor of *Medical Economics,* writes in a recent issue of that magazine on "Antipoverty Medicine: Atlanta to Watts," contrasts the success of Atlanta with that of the widely publicized Watts area of Los Angeles. He charges the trouble in Watts to the "traditional town-gown friction, aggravated by racial antipathy."

The University of Southern California School of Medicine made the antipoverty-care proposal, got the grant, and administers the health-care center. Private physicians in Watts resented the U. S. C.'s take-over, and the battle was on.

By contrast the Medical Society of Fulton County and the Emory University School of Medicine took the initiative, the society obtained an O. E. O. grant for Atlanta's Price Neighborhood Health Center, and subcontracted the running of it to Emory. Two plans representing typical approaches to two main currents of medical thinking about how to get care to the poor: pay-doctors-a-salary vs. pay-patients-for-their-medical-expenses, are plans that are intermingling without turbulence. And Dr. Linton H. Bishop, Jr., president of Fulton County's Medical Society, says: "the two approaches are by no means mutually exclusive. Atlanta may need both."

Dr. Richard Magraw, author of *Ferment in Medicine,* believes "the elements of a medical Armageddon—a great final conflict—are beginning to form. If, through failure to respond to the challenge of antipoverty health care, private medicine either defaults or loses this battle, it could well lose the entire battle for its survival."

Interesting, yes?

PHYSICIAN PLACEMENT SERVICE IN ALABAMA

The Physician Placement Service of the Medical Association of the State of Alabama is designed to assist both physicians and communities. MASA members having knowledge of practice opportunities or wishing to relocate their own practices are urged to communicate with the Placement Service. For further information: write Mr. Emmett Wyatt, Executive Assistant, Medical Association of the State of Alabama, 19 South Jackson Street, Montgomery, Alabama 36104, or Telephone 263-6441.

Locations Wanted

General Practice—

Age 27; Louisiana State University 1967; seeking group or associate practice. Available August 1968. LW-335

Age 38; University of Oklahoma, 1955; seeking associate, institutional or industrial practice; in town of 10,000 plus population; interest in surgery. LW-336

Age 28; University of Tennessee, 1965; available November 1968. LW-337

Age 28; Medical College of Alabama 1966; seeking practice in town of less than 14,000 population to fulfill scholarship requirements. Available 1968. LW-338

Age 52; University of Chicago 1950; seeking group, industrial, institutional or student health position. LW-339

Age 56; Georgetown University 1938; seeking solo, group or associate practice, with general surgery. Available July 1968. LW-340

Internal Medicine—

Age 34; Hahnemann Medical College 1959; Board eligible, National Board; seeking solo, group, or associate practice. Available immediately. LW-342

Age 34; University of Tennessee, 1958; American Board Certified, seeking group, industrial, or institutional practice. Available Spring 1968. LW-343

Age 34; University of Mississippi 1960; Board eligible; seeking location in southern section of Alabama in city of 15,000 plus population. LW-343-2

University of Mississippi 1963; seeking group practice in city of 20,000-40,000 population. LW-343-3

Neurology—

Age 31; Harvard 1962; Board eligible; National Board; seeking solo, group or associate practice. Available July 1969. LW-344

Age 30; Medical College of Alabama 1962; Board eligible; National Board; seeking solo, group, associate or institutional practice. Available January 1969. LW-345

Age 31; University of Virginia 1962; Board eligible; seeking associate or group practice. Available August 1969. LW-345/1

Obstetrics-Gynecology—

Age 35; Vanderbilt University 1950; Board eligible; Available July 1968. LW-346

Age 37; University of Virginia 1959; Board certified; seeking group or associate practice. Available September 1968. LW-347

Age 34; University of Missouri 1959; Board certified; seeking group, industrial, associate or institutional practice. Available July 1968. LW-348

Age 36; Medical College of Alabama 1957; Board eligible; seeking group or associate practice. Available immediately. LW-348-A

Radiology—

Age 31; S. U. N. Y. College of Medicine, 1961; Board eligible; seeking solo, group, or associate practice. LW-350

Age 41; Cornell Univ. Medical School, 1953; Board certified; seeking group, or associate practice. Available immediately. LW-351

Age 51; Univ. of Texas Med. Branch, 1942; Board certified; seeking solo, group, or associate practice. LW-352

Age 39; Louisiana State University 1954; seeking solo or associate practice. Available July 1969. LW-352/1

Surgery—

Age 33; University of Missouri, 1961; seeking group or associate practice. Available January 1969. LW-353

Age 38; Emory University, 1956; Board eligible; seeking group, associate, or institutional practice. Available July 1968. LW-354

Age 37; Faculty of Medicine, Manitoba, 1957; Board certified; seeking associate or institutional practice. Available July 1968. LW-355

Age 34; Board eligible; University of Santo Tomas, 1961; seeking group or associate practice. Available July 1968. LW-356

Age 35; Board eligible; Univ. of Santo Tomas, 1956; seeking solo, group, industrial or associate or institutional practice with general practice. Available immediately. LW-357

Urology—

Age 30; Louisiana State University 1963; Board eligible; seeking associate or group practice. Available July 1969. LW-358

• • •

Physicians Wanted

General Practitioners—

Opportunity for group practice in town of 10,000 population in north Alabama. PW-211

Physician wanted to join 39 year old Medical College of Alabama graduate in a well established general practice in West Central Alabama town. Salary initially followed soon by full partnership. PW-211-1

Opportunity in community of 5,000 population in trade area of 30,000 population located in northeast Alabama where at present time there are only two active full time general practitioners. Modern of-

PHYSICIANS WANTED

(Continued)

fices or clinic facilities available. 48-bed accredited hospital and 52-bed skilled nursing home adjoining the hospital. Cities of approximately 75,000 population located within 25 miles distance. Agricultural and expanding industrial area. Numerous churches and schools. Country club and golf course being developed and water sports and outdoor activities offer recreational advantages. PW-211-2

For town in South Alabama with 20,000 trade area, within 40 miles of Gulf beaches and large city. Excellent hunting and fishing. Numerous industries offering stable employment for area. Furnished office available rent free. Hospital presently engaged in complete remodeling and expansion. PW-212

For town of 4,500 population in trade area of 10,000 to 15,000 with annual payroll of 4½ million dollars, located in north central Alabama. Within 75 and 85 miles respectively of two metropolitan areas with combined population of 2 million. Hospital privileges available in modern 30-bed hospital. A modern 40-bed extended care facility adjoins hospital. Excellent churches, schools and shopping areas. In the center of the best hunting, fishing and recreational area in the state. PW-212/1

Physician wanted to join well established partnership in Northwest Alabama city of 15,000 population. Two accredited hospitals, junior college, schools, churches, recreational activities. No obstetrics or surgery. New office building. PW-212/2

For city of approximately 15,000 population in north Alabama, with trade area of approximately 45,000 population. Hospital with over 100 beds, and expansion planned for next year. Nursing homes in the area. Industrial growth and agricultural region. Several churches and schools. Golf course, civic and fraternal organizations. PW-212/3

Unusual opportunity for two general practitioners with military obligations satisfied at a modern fifty bed facility located 15 minutes drive from largest metropolitan center in north-central Alabama. Construction of a new two-story office building is scheduled to begin soon. PW-213

Opportunity in rapidly expanding community of 10,000-12,000 population adjacent to metropolitan center in north Alabama. Office space free for six months and equipment available. Staff privileges at nearby hospitals. PW-214

For town of 3,600 population in trade area of 5,000-7,000 within 100 miles of two large cities and the Gulf Coast. 50-bed hospital located in the town. Office space available. Agricultural and expanding industrial area. Several churches and two schools. Recreational activities in the town as well as nearby—golf course, hunting and fishing. PW-215

For town of approximately 1,000 population in North-central Alabama in trade area of 12,000 population. 100-bed hospital in adjoining city. PW-216

For town of 12,500 population in trade area of 50,000 located in South Alabama. Nearest large city with population of 145,000 is 80 miles. One of the physicians died recently. Two hospitals with 140 beds. Numerous small industries; several churches and schools. Recreational activities include water sports and golf course. PW-217

For town of approximately 1,000 population in population center of 10,000 located in Southwest Alabama within 90 miles of the Gulf coast. City owned clinic is offered rent free and fully equipped. Hospitals are located in two nearby towns within 25 miles. This is principally an agricultural region, but there are military installations nearby. Numerous civic clubs, community concert series, and a country club offer recreational activities. PW-218

For town with 1,000 population in trade area of 5,000 Southeast Alabama. Nearest large city with population of 50,000 is 55 miles. New clinic available rent free. No physicians in the town. Hospitals in surrounding town within 30 miles. Several churches and schools. PW-219

Opportunity in city of 5,000 population located in Northeast Alabama in trade area of approximately 10,000 population. Office space available. One physician died recently. Hospital and nursing home in the city. PW-220

For town of 1,000 plus population in west-central Alabama in trade area of 20,000. Clinic available. Nearest city of approximately 70,000 population is located a distance of 17 miles. Farming, cattle, timber, and manufacturing plants are principal resources of the area. Churches, schools, and recreational advantages. PW-221

For solo practice in town of approximately 17,000 population located in east central Alabama. 48-bed general hospital. Arrangements available for office space. Excellent recreational advantages which include hunting, fishing and water sports. City owned airport. Numerous civic clubs. Excellent schools and churches. Expanding industrial and agricultural area. PW-222

Opportunity for one or more doctors in rapidly expanding eastern suburb of Birmingham. Attractive brick building consisting of 10 rooms and adjacent parking facilities. PW-223

Opportunity for general practitioner to join a five-man group, practicing as a partnership. Each man in the group is either specialized or semi-specialized. The practice is physically located within a 70-bed hospital. Willing to pay qualified person $36,000 for the first year, with possible partnership status in one year. Would consider a physician for locum tenens for three to six months at $2,000 per month. PW-224

Opportunity in centrally located town in North Alabama in trade area of 10,000-15,000 population. The only doctor is retiring. Housing and office space readily available. Churches and schools. Recreational advantages of nearby lakes. PW-225

Surgeon—

Opportunity for a Board eligible or Certified surgeon to practice in city of over 78,000 popula-

(Continued on Next Page)

Physicians Wanted

(Continued)

tion in north Alabama. Equipment available. PW-226

Specialist in the following fields: Internal Medicine, Pediatrics, Obstetrics-Gynecology and General Practitioners. 58 bed fully accredited general hospital with 91 bed addition to be completed in July 1968. Modern new office space available. PW-227

Physician interested in Internal Medicine and Chest Diseases to provide general medical services in 184 bed Tuberculosis Hospital in North Alabama. References and experience data required in advance. U. S. citizens and fully licensed physicians given first choice. Others will be considered upon request. Salary open. PW-229

Special Openings

Opportunity for physician interested in joining a progressive public health tuberculosis control program working in Birmingham, Jefferson County. Provide outpatient medical services and some administrative duties. Fringe benefits and salary open. PW-230

Not just a motel
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. . . with 171 handsome rooms designed for your comfort and convenience. A center-of-everything location including Birmingham's University of Alabama Medical Center . . . making The Guest House a favorite of Doctor's wives and in-town outpatients. Superb dining, dancing and nightly entertainment. Come stay with us often.

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"Where the Action Is!"

Narcotic Addicts Committed For Examination-Treatment

As of May 15, 1968, over 450 narcotic addicts had been committed for examination or treatment under a new Federal program administered by the National Institute of Mental Health.

The Narcotic Addict Rehabilitation Act of 1966 is a **total** treatment program that views narcotic addiction as an illness rather than a crime.

The law provides for the civil commitment of addicts, including those charged with or convicted of violating certain Federal criminal laws as well as others not charged with an offense. Addicts who have committed a crime of violence are ineligible.

For the first time the Federal government is assuming the responsibility for aftercare services, which are to be developed in the addict's home community. The NIMH is also administering a grant support program authorized by this Act for States, local governments and organizations to develop community treatment and rehabilitation facilities.

Field offices have been set up in New York, Chicago, and Los Angeles, providing consultation to local planners and negotiating and monitoring contracts for providing aftercare. Offices will be established in the near future in many other cities where there is a high incidence of narcotic addiction.

The NIMH is responsible for the administration of all aspects of the program except those pertaining to the treatment of convicted criminals. This phase of the program is administered by the Office of the Attorney General in cooperation with the NIMH.

Senior of All Doctors—Shamblin Qualifies for MASA's 50-Year Club

To say the Doctors Shamblin of Tuscaloosa are as numerous as the sands of the sea, would be a slight exaggeration. But if you count a son-in-law, who is right next to them alphabetically, there is one for every day of the week!

Senior of the group is Dr. William Grover Shamblin, who last January 10th was 75 years old. And besides being the first of his family to pursue the practice of medicine, there are other "firsts" that set him apart, beginning with the fact that he was graduated from the University of Alabama without ever seeing the inside of a high school classroom!

In those distant days, in 1911, one could get into Alabama Polytechnic Institute (as Auburn was then known) with an entrance examination, without the need of school records of any kind. He passed his, completed his freshman course, and with his father approached Dr. George Denny for admission to the new two-year pre-med course just established at the University. Dr. Denny could see no reason why one should not transfer from another accredited school without reference to earlier schooling.

He will be the first of the Shamblins and one of three Alabama doctors to qualify next April for the 50-year club, having completed half a century of membership in the Medical Association of the State of Alabama.

So to set him and his wife apart from the numerous others of that name and profession, it was inevitable that this happy partnership should become known as "the *old* Dr. Shamblins." Nor was Mrs. Shamblin any less a medical partner because she had no M. D. degree. One busy day—and night!—out of their routine was a pattern:

Dr. Shamblin was up early and to surgery, then to his office, then on a round of in-town house visits. After supper, with his wife driving the car, he would make his rural



Dr. Wm. G. Shamblin

rounds, napping on the back seat when there was time. They wore miner's caps with lights, so he could see to walk roads and paths the car could not negotiate, and so Mrs. Shamblin could read or sew while waiting for him, often in winter with a hot-water bottle at her feet.

An incurable football fan, it was not unusual for him to call home, tell his wife to "pick me up at the hospital at midnight," and then drive the rest of the night to Knoxville or Nashville or Atlanta to see the Crimson Tide in gridiron combat.

In 1934, on their first extended vacation, he took the entire family including Mrs. Shamblin and their three daughters, to California to see Alabama roll over Leland Stanford University in the Rose Bowl, 29 to 13. Those were the days when Dixie Howell-to-Don Hutson was an unbeatable passing com-

(Continued on Page 422)



Summation:
In addition to its primary indications for duodenal and gastric ulcer, Robinul Forte (glycopyrrolate) is indicated for other G-I conditions that may benefit from anticholinergic therapy. Robinul-PH Forte (glycopyrrolate 2 mg. with phenobarbital) is indicated when these situations are complicated by mild anxiety and tension.

Contraindications: Glaucoma, urinary bladder neck obstruction, pyloric obstruction, stenosis with significant gastric retention, prostatic hypertrophy, duodenal obstruction, cardiospasm (megaesophagus), and achalasia of the esophagus, and in the case of Robinul-PH Forte, sensitivity to phenobarbital.

Precautions: Administer with caution in the presence of incipient glaucoma.

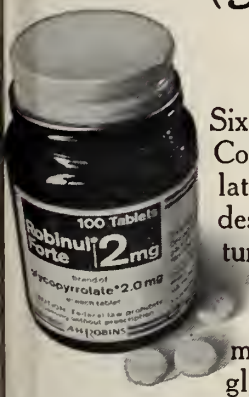
Adverse Reactions: Dryness of the mouth, blurred vision, urinary difficulties, and constipation are rarely troublesome and may generally be controlled by reduction of dosage. Other side effects associated with the use of anticholinergic drugs include tachycardia, palpitation, dilatation of the pupil, increased ocular tension, weakness, nausea, vomiting, headache, dizziness, drowsiness, and rash.

Dosage: Should be adjusted according to individual patient response. Average and maximum recommended dose is 1 tablet three times a day; in the a.m., early p.m., and at bedtime. See product literature for full prescribing information.

Supply: Robinul (glycopyrrolate 1 mg.): Robinul Forte (glycopyrrolate 2 mg.): Robinul-PH (glycopyrrolate 1 mg.) with phenobarbital 16.2 mg. (Warning: may be habit forming); Robinul-PH Forte (glycopyrrolate 2 mg.) with phenobarbital 16.2 mg. (Warning: may be habit forming), in bottles of 100 and 500 tablets. A. H. Robins Company, Richmond, Va. 23220.

A·H·ROBINS

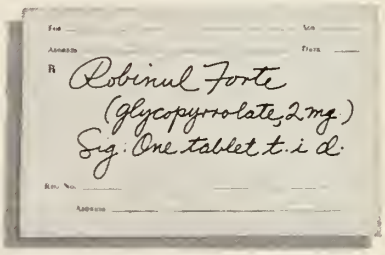
In peptic ulcer therapy, won't you give Robinul® Forte a Fair Trial?
(glycopyrrolate)



Six years ago the A. H. Robins Company introduced glycopyrrolate, a unique anticholinergic agent described in the prescribing literature as more closely approaching the ideal compound for controlling gastric hyperacidity and hypermotility of the G-I tract. Although glycopyrrolate (Robinul Forte) found good acceptance among numerous physicians, many others just didn't seem to want to give it a try, probably because the anticholinergic they were already using was giving acceptable results.

However, we believe you'll agree there's always room for a better anticholinergic. This is why we're asking you to give Robinul Forte a fair trial. Robinul Forte exerts a highly specific antisecretory action and marked inhibitory effect on intestinal tone. We're convinced you'll agree that this is indeed an outstanding drug when you observe its outstanding suppression of ulcer symptoms. Furthermore, it is unique in that it reduces intestinal tone, yet has little or no effect on peristalsis. In addition, the incidence of the more bothersome peripheral side effects is low.

No longer does the physician have to look for extreme dry mouth as the measure of his anticholinergic's effectiveness. The only way we can demonstrate to you firsthand the efficacy of glycopyrrolate (Robinul Forte) is for you to try it in your practice. That's why we're asking you to give it a Fair Trial. How can you give it a Fair Trial? You do it this way:



First: When you see your very next ulcer patient, write him a script as shown.

Next: Wait 10 days or until your patient comes in for his next appointment and get his "verdict" as to how he feels. Examine all the evidence and make your evaluation of his condition.



Finally: Render **your** verdict. If it's "significant improvement and marked relief of symptoms," then we believe you'll agree that Robinul Forte has proved its worth, and we rest our case. If not, consider our case for Robinul Forte closed. That's a Fair Trial, Doctor, and it's all we ask.

Robinul® Forte
(glycopyrrolate, 2 mg.)

The summation is an important part of every case. You'll find ours on the preceding page, Doctor.

(Continued from Page 419)

bination, and when Bear Bryant was playing end, opposite Hutson.

Perhaps it was this rest-less life that led in 1945 to three successive heart attacks and to his retirement, when he swapped the hospital for the farm, the ailing patients for the browsing kine. Telephone conversations with friends and napping before the TV screen, are his principal diversions when one of their eleven grandchildren isn't around to occupy his time away from the farm.

"The ramblin' Shamblins" may have rhyme in it—but not truth! There's no such thing as a ramblin' Shamblin! They all come home, beginning with the eldest, Dr. William Grover Shamblin, and continuing to the third and, in time, the fourth generation of doctors.

Immunization Information Available

"Immunization," a five-page statement which originally appeared in the April 8, 1968 issue of *The Journal of the American Medical Association,* has been reproduced and is now available to those who would like a copy.

The opening paragraph states that since man has become aware that immunization is vitally important, he has wisely used various methods of immunization—relying on vaccines as the basic tool of preventive medicine. "The freedom from smallpox in the United States for 19 years by means of vaccination is an example of such reliance. On the other hand, the continued existence of smallpox in some other countries is an indication of the inadequate use of vaccination," the paper points out.

The physician's role, recommended immunization schedules for such diseases as tetanus, diphtheria, pertussis, smallpox, poliomyelitis and measles and immunizations for travel are all explored in this informative reprint. The recommendations are those of the AMA's Council on Environmental and Public Health and bear no formal concurrence or endorsement of any other organizations.

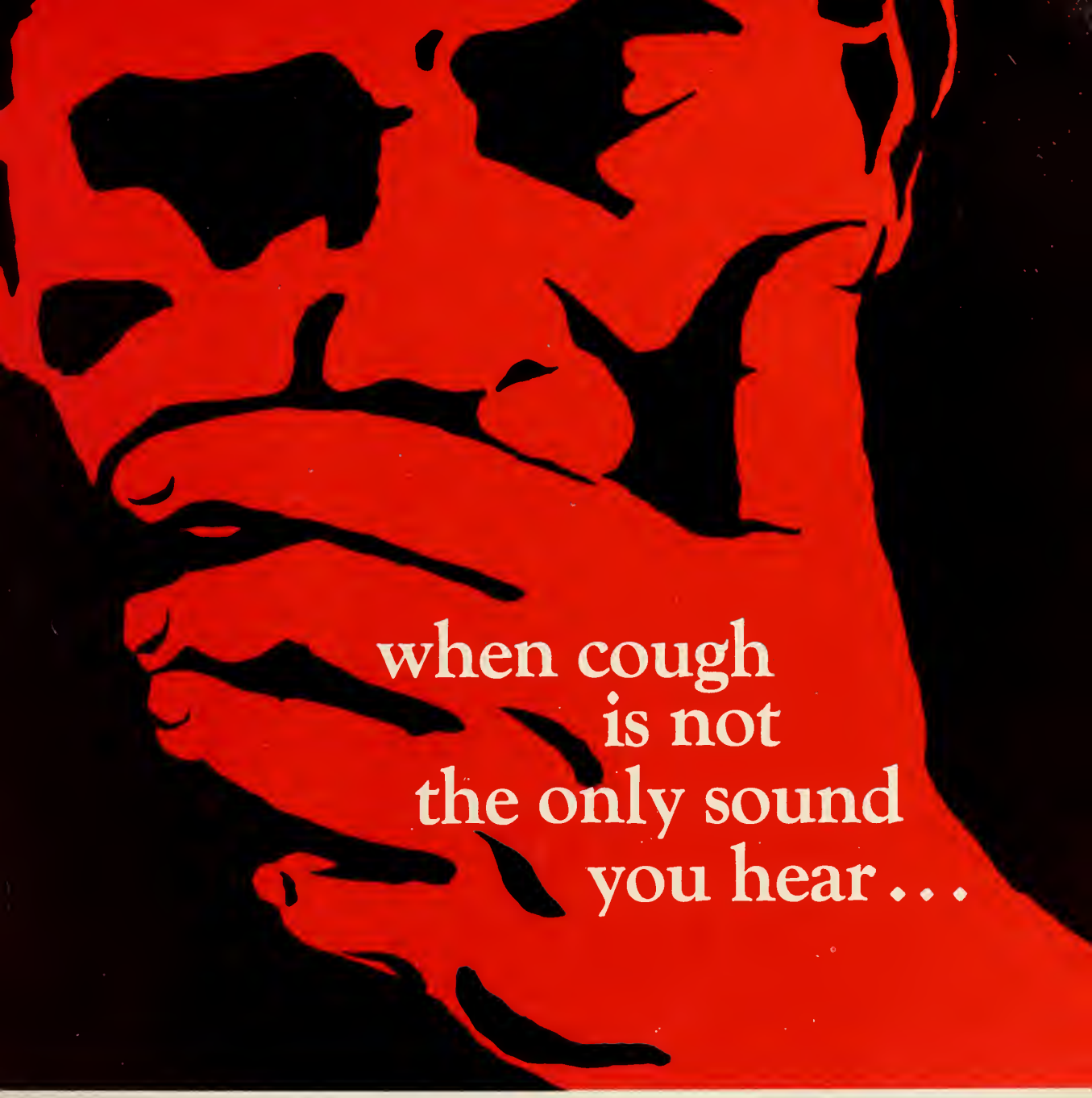
To obtain a complimentary copy of this article, simply direct your inquiry to the Department of Environmental Health, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

Curious About Dandruff?

If you're curious about dandruff and its effects, you can now replace this curiosity with knowledge simply by obtaining a copy of "Dandruff," an eight-page pamphlet recently produced by the Committee on Cutaneous Health and Cosmetics of the American Medical Association.

This brochure, developed to enlighten the public concerning dandruff, its suspected causes and possible control, estimates that nearly 94 per cent of the U. S. population is affected by this condition at one time or another. Further, it points out that $67,000,000 is spent yearly for anti-dandruff shampoos, rinses, hairdressings and prescription items. The "Brand-Name Guide to Anti-dandruff Products," which is included in this publication, lists the active ingredients of available products that are effective in treating this annoying problem.

To become better informed, request a complimentary review copy of "Dandruff" from the AMA's Committee on Cutaneous Health and Cosmetics, 535 North Dearborn Street, Chicago, Illinois 60610. To expedite handling, quantity orders should be coded "OP-29" and directed to the Order Unit. Quantity prices are as follows: 50-99 copies, 18c each; 100-499, 16c each; 500-999, 14c each; 1,000 or more, 12c each.



OMNI-TUSS® b.i.d.

. . . **because** OMNI-TUSS is indicated for cough associated with upper respiratory tract infections, bronchitis, bronchiectasis, bronchial asthma, emphysema, sinusitis and rhinitis, hay fever, or other allergic conditions. Any of these conditions may exhibit the general symptom syndrome—coughing, wheezing, bronchospasm, and tenacious mucus—which may benefit from the antitussive, bronchodilative, antihistaminic, and expectorant action of Omni-Tuss.

The therapeutic usefulness of Omni-Tuss is enhanced by a unique resin complex formulation providing the clinically desirable advantages of: (1) uniform drug availability throughout an extended period, (2) 8 to 12 hours of symptomatic control, (3) minimal dosage requirement, (4) minimal side effects.

Economical, efficient **b.i.d.** dosage—extremely well-tolerated by children, 6-12, and adults.

'Omni Tuss' Suspension: Each teaspoonful (5 cc.) contains 10 mg. codeine (Warning: May be habit-forming), 5 mg. phenyltoloxamine, 3 mg. chlorpheniramine, 25 mg. ephedrine, all as cation exchange resin complexes of sulfonated polystyrene, and 20 mg. guaiacol carbonate.

Available on prescription only. Class X exempt narcotic. Permissible on oral prescription.

Dosage: *Adults:* 1 teaspoonful (5 cc.) q12h.
Children (6-12 *years*): ½ teaspoonful q12h.

Side Effects: Minimal, but when encountered may include jitteriness, nausea, drying of mouth, insomnia, constipation, which disappear upon adjustment of the dose or discontinuance of treatment.

Precautions and Contraindications: For complete detailed information, refer to package insert or official brochure.

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When it's more than a bad cold



your patient can feel better while she's getting better

Achrocidin®

Tetracycline HCl—Antihistamine—Analgesic Compound

Each tablet contains: ACHROMYCIN® Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Caffeine 30 mg.; Salicylamide 150 mg.; Chlorothen citrate 25 mg.

In tetracycline-sensitive bacterial infection complicating respiratory allergy, ACHROCIDIN brings the treatment together in a single prescription—prompt relief of headache and congestion together with effective control of the organisms frequently responsible for complications leading to prolonged disability in the susceptible patient.

For children and elderly patients you may prefer caffeine-free ACHROCIDIN Syrup. Each 5 cc contains: ACHROMYCIN (Tetracycline) equivalent to Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Salicylamide 150 mg.; Ascorbic Acid (C) 25 mg.; Pyrilamine Maleate 15 mg.

Contraindications: Hypersensitivity to any component.

Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.

Precautions: Drowsiness, anorexia, slight gastric distress can occur. In excessive drowsiness, consider longer dosage intervals. Persons on full dosage should not operate vehicles. Nonsusceptible organisms may overgrow; treat superinfection appropriately. Treat beta-hemolytic streptococcal infections at least 10 days to help prevent rheumatic fever or acute glomerulonephritis. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity* reactions—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

Upon adverse reaction, stop medication and treat appropriately.

Lederle

327-8



NEW! THE RITTER COAGULATOR

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The Ritter Coagulator is a low-in-cost but high-in-quality electrocoagulation instrument for wall or shelf service in your office. Made by the makers of the famous hospital Bovie, it has been engineered to utilize every advantage of today's advanced state of electronic circuitry. It will coagulate, desiccate and fulgurate—and you can handle scores of day-to-day applications in dermatology, gynecology, rhinolaryngology and proctology. Easy, safe to operate. Compact—only 8½ x 5 x 4 inches. Ask for a demonstration.

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Nothing else I've tried seems to work, so I decided to give you a crack at it.

Some U.R.I. patients are more miserable than others.

That's why we make Novahistine® tablets in two different formulations.

And let you control the dosage.

With Novahistine LP tablets and Novahistine Singlet tablets you have the range and flexibility of decongestant dosage that lets you prescribe for the needs of the individual patient.

Novahistine LP tablets are most useful for relief of nasal congestion in patients without pain or fever.

Novahistine Singlet tablets, which provide analgesic-antipyretic effect, as well as decongestant action, are indicated for upper respiratory infections accompanied by pain, aches and fever.

Whether you prescribe Novahistine LP or Novahistine Singlet, a total daily dose of 3 or 4 tablets will usually provide effective, continuous relief.

Use cautiously in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

Each Novahistine LP tablet contains phenylephrine hydrochloride, 25 mg; and chlorpheniramine maleate, 4 mg.

Each Novahistine Singlet tablet contains phenylephrine hydrochloride, 40 mg, chlorpheniramine maleate, 8 mg; and acetaminophen, 500 mg.



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It's almost as if you were there to give an injection of penicillin



V-Cillin K®, Pediatric dependable oral penicillin therapy

Potassium Phenoxymethyl Penicillin

Description: V-Cillin K, the potassium salt of V-Cillin® (phenoxymethyl penicillin, Lilly), combines acid stability with immediate solubility and rapid absorption. Higher, more rapid serum levels are obtained than with equal oral doses of penicillin G.

Indications: Streptococcus, pneumococcus, and gonococcus infections; infections caused by sensitive strains of staphylococci; prophylaxis of streptococcus infections in patients with a history of rheumatic fever; and prevention of bacterial endocarditis after tonsillectomy and tooth extraction in patients with a history of rheumatic fever or congenital heart disease.

Contraindication: Penicillin hypersensitivity.

Warnings: In rare instances, penicillin may cause acute anaphylaxis which may prove fatal unless promptly controlled. This type of reaction appears more frequently in patients with a history of sensitivity reactions to penicillin or with bronchial asthma or other allergies. Resuscitative drugs should be readily available. These include epinephrine and pressor drugs (as well as oxygen for inhalation) for immediate allergic manifestations and antihistamines and corticosteroids for delayed effects.

Precautions: Use cautiously, if at all, in a patient with a strongly positive history of allergy.

In prolonged therapy with penicillin, and particularly with high parenteral dosage schedules, frequent evaluation of the renal and hematopoietic systems is recommended.

In suspected staphylococcus infections, proper laboratory studies (including sensitivity tests) should be performed.

The use of penicillin may be associated with the overgrowth of penicillin-insensitive organisms. In such cases, discontinue administration and take appropriate measures.

Adverse Reactions: Although serious allergic reactions are much less common with oral penicillin than with intramuscular forms, manifestations of penicillin allergy may occur.

Penicillin is a substance of low toxicity, but it possesses a significant index of sensitization. The following hypersensitivity reactions have been reported: skin rashes ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; and reactions resembling serum sickness, including chills, fever, edema, arthralgia, and prostration. Severe and often fatal anaphylaxis has occurred (see Warnings). Hemolytic anemia, leukopenia, thrombocytopenia, and nephropathy are rarely observed side-effects and are usually associated with high parenteral dosage.

Administration and Dosage: Usual dosage range, 125 mg. (200,000 units) three times a day to 500 mg. (800,000 units) every four hours. For infants, 50 mg. per Kg. per day divided into three doses.

See package literature for detailed dosage instructions for prophylaxis of streptococcus infections, surgery, gonorrhea, and severe infections.

How Supplied: Tablets V-Cillin K® (Potassium Phenoxymethyl Penicillin Tablets, U.S.P.), 125 mg. (200,000 units), 250 mg. (400,000 units), and 500 mg. (800,000 units).

V-Cillin K® (potassium phenoxymethyl penicillin, Lilly), Pediatric, for Oral Solution, 125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc. of solution (approximately one teaspoonful). [042567A] 800198

Additional information available to physicians upon request.

Eli Lilly and Company, Indianapolis, Indiana 46206

Lilly

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Hazards Of Wearing Contact Lenses

Joseph M. Dixon, M. D.

Birmingham, Alabama USA

The hazards of wearing contact lenses consist mainly of those ocular changes caused by the lenses. Some of these changes are minor and temporary while other changes are serious, and may result in permanent damage to or loss of vision.

A previous report by the contact lens committee of the American Association of Ophthalmology has documented cases of 14 eyes blinded while wearing contact lenses, 157 permanently damaged, and 7607 cases of temporary injuries.[1] This discussion is limited to the hazards and complications of wearing contact lenses and does not include the indications and benefits.

Hazards of Transient Damage

Ophthalmologists who provide medical care for patients who wear contact lenses are familiar with the many routine daily eye changes caused by the lenses. These common and usually harmless changes have been reported by Dixon[2] and may be listed as follows:



Dr. Joseph M. Dixon

1. Congestion of the conjunctival vessels, edema of the lids and conjunctiva, and increased flow of tears. In rare cases the conjunctival hyperemia is so severe and persistent it produces an unsightly appearance that makes it necessary to discontinue wearing the lenses.

2. Mechanical loss of corneal epithelium with resulting stain with fluorescein. This loss of epithelium may be caused by acciden-

Presented at The Joint Scientific Meeting of the Japan Contact Lens Society and the Contact Lens Association of Ophthalmology, Iizaka-machi, Fukushima, Japan, July 21, 1968.

tal injury when inserting and removing the lenses. It may also be produced by poorly fitting lenses which are too steep, too flat, or by warping of the plastic lenses.

3. Foreign bodies which float under the lenses in the tear fluid become trapped between the lens and the cornea causing sudden pain and corneal scratches. Immediate removal of the lens is necessary unless the foreign body quickly floats away in the tears.

4. Central corneal erosion and abrasions caused by wearing corneal lenses too long. This has been called the overwearing syndrome and is manifest typically by severe pain and lid spasm which appears after the lenses are removed. It is common in patients fitted with new lenses who are comfortable while wearing the lenses and do not realize the danger of wearing lenses too long. After the lenses are removed and pain appears, an examination of the cornea by biomicroscopy reveals an irregular central area of corneal epithelium which stains with fluorescein in an irregular pattern and with variable density. This area will heal in one to two days if the lenses are not worn. A hazard of this lesion is the danger of pathogenic bacteria invading the broken epithelium and producing an ulcer of the cornea.

Hazards of Prolonged Reversible Damage

Decreased Corneal Sensitivity

1. A more prolonged but reversible eye change which presents certain hazards is the decrease in corneal sensitivity found in patients well adapted to corneal lens wear. The center of the cornea is normally more sensitive to touch than the periphery. Those patients who become adapted to daily corneal lens wear have reduced sensitivity of the central and peripheral cornea as well as the tarsal epithelial surface of the upper lid. This reduced sensitivity will recover within a few days if the lenses are discontinued but there is an added hazard of injury to the cornea during a period of reduced sensitivity.

2. **Spectacle blur**—Spectacle blur is the blurred vision experienced when spectacles are worn after contact lenses are removed. Spectacle blur is common and may persist from several minutes to several weeks. The etiology is not well understood but there are probably several factors, such as distortion of the soft corneal epithelium and alterations in the anterior or posterior corneal curvatures. Alteration of the refractive index of the cornea could be a factor.

The usual clinical picture of spectacle blur consists of blurred vision that may persist for 1 week after corneal lenses are discontinued and the refractive error of the eye will not be corrected to 20/20 by glasses during that period. For this reason patients who have worn corneal lenses habitually for several months or several years must discontinue wearing corneal lenses at least 1 week before being refracted for new spectacles. Occasionally, at the end of one week the vision cannot be corrected to 20/20 and the refraction is repeated in another week. Keratometer readings immediately after removal of corneal lenses are frequently inaccurate and the reflections of the mires from the corneal surface are distorted.

Hazards of Permanent Damage to the Eye

Permanent damage to the eyes or vision or total loss of an eye is not common but may result from wearing corneal lenses. The most common and most serious eye complication caused by contact lenses is secondary infection.

Bacterial Infections

Cultures of the lids and conjunctiva on blood agar plates made before wearing corneal lenses compared with similar cultures repeated on the same patient while wearing contact lenses daily indicate that there is no alteration in the normal lid and conjunctival flora.[3]

The contamination of contact lens containers with pathogenic organisms is common and is a dangerous source of infection. A common inhabitant of unclean containers is P. aeruginosa. Pseudomonas was recovered

from 10 percent of 85 lens containers cultured. This organism is frequent in eyes destroyed by endophthalmitis or permanently damaged by corneal ulcers while wearing contact lenses. Staphlococcus aureus is frequently cultured in purulent conjunctivitis complicating contact lens wear.

The prevention of these serious complications requires attention of physicians and patients to cleanliness of the contact lens containers, the lenses, and the hands used to insert the lenses on the corneas. Lenses should be removed as soon as injury or irritation of the eyes is discovered.

The wearing of a contact lens on an eye with a filtering cicatrix from cataract surgery or following a filtering procedure for glaucoma is especially hazardous. The contact lens is a foreign body which invites infection and the filtering area invites endophthalmitis. This has occurred in three patients.[1]

Viral Infection

Infections of the cornea by the herpes simplex virus may occur while wearing corneal lenses. This complication depends largely upon the immune resistance of the patient. It has been demonstrated in rabbits that an infection of the cornea by the herpes virus is made more severe by the presence of a corneal lens. Clinical experience has shown that the appearance of a corneal infection by herpes simplex is easily overlooked in the presence of a corneal lens because the lesion is not typical. It takes the geographic ulcer form rather than the dendritic figure. Patients who have an active infection with herpes on other areas of the body should not wear contact lenses until all infection disappears.

Fungus Infection

Four of the 14 eyes blinded by complications of contact lenses are reported by Dixon[1] and others were lost by infection of Candida albicans. This monilia is usually a harmless inhabitant of the body but its growth is increased in constantly moist areas such as the mouth and genital tract. It is not surprising that this organism would invade the cornea under a contact lens where there is constant trauma and moisture. The protective sweeping action of the lids over the cornea is prevented by the lens.

Corneal Vascularization

Vascularization of the cornea at the area where a contact lens rests across the limbus and fails to move during blinking has been reported in another paper.[4] This complication is insidious because the patient is not aware of its presence. This form of pannus is discovered by the ophthalmologist during routine examination of the eye with the biomicroscope.

Miscellaneous Hazards

In a number of cases, a corneal lens has been found in the upper fornix of the eye after being lost for many months.[5] By this time the lens has become inbedded in the tissue of the lid to form a foreign body type of granuloma.

Hazards of Defective Lenses

Defective contact lenses are a common cause of eye irritation and trauma. Defects in manufacture may consist of poorly polished lenses, poor blending of posterior curves, warped lenses, lathe marks on lens surfaces, wax and other debris not cleaned from lens surface, edges too sharp, edges chipped, edges poorly finished and lenses poorly designed.

A perfectly manufactured and finished lens very commonly becomes defective because of careless handling by patients. The commonly used lens is made of polymethacrylate, is relatively soft and easily damaged. Many patients are not aware that contact lenses do not endure daily handling forever and must eventually be replaced. The public is concerned about harmless scratches on spectacle lenses. These same people will wear irritating, scratched and damaged

lenses in their eyes for long periods before seeking medical attention. The clinical picture is typical of the patient who wears comfortable and well fitting lenses for several years while neglecting the necessary routine medical examination. The eyes then become irritated, there is daily epiphora, hyperemia of the conjunctiva, and lid edema. Secondary purulent conjunctivitis may appear. At the time of a medical consultation the lenses are found to be extremely scratched and abrasive to the eyes. Simple polishing equipment should be available in the physician's office for maintenance of the lens surface and edges until replacement is necessary. Deep scratches cannot be removed but brief polishing will remove the rough edges of the scratches.

Other lens damage consists of lenses warped by squeezing or excessive bending with the fingers, chipping the edges and damage in lens containers.

Unlike spectacle lenses, contact lenses are easily reversed and when very dissimilar may damage the eyes by fitting improperly.

Non Ocular Hazards

Hazards exist for individuals who wear contact lenses and who operate high speed vehicles. Inability to see due to sudden loss of both lenses is a serious danger. Usually, only one lens is lost and the individual is able to see well enough with the other eye to control the vehicle. A foreign body suddenly trapped between the lens and the cornea is another type of emergency because of the pain and lid spasm. Operators of public transportation, where the lives of many others are involved must be carefully evaluated by medical authorities familiar with contact lens problems.

An individual with only one eye and whose vision is less than 20/100 without correction should not operate high speed vehicles while wearing a contact lens. Sudden loss of the lens would create an excessively dangerous emergency.

Hazards of External Injury

There is very little danger to the eyes by external trauma while wearing corneal lenses, and that part of the eye covered by the lens may be slightly protected. The lens is very thin and could only protect the eye from minor trauma. Contact lenses cannot replace industrial safety glasses.

While wearing contact lenses, caustic chemicals splashed in an eye would be difficult to remove in an emergency and chemical burn to the eye would be increased.

Hazards of Unconsciousness

Epilepsy, insulin shock, cerebrovascular accidents, and head injuries render patients unconscious without an opportunity to remove the contact lenses. When the unconsciousness state is prolonged for several hours or days, serious damage to the eyes may result, usually caused by purulent infection and endophthalmitis. The loss of an eye by endophthalmitis has occurred in a patient wearing contact lenses who drank alcohol excessively and was unconscious an entire night.

Prevention of Hazards

The hazards of wearing contact lenses are present in the one and one half million people wearing contact lenses in Japan and the estimated 3 to 5 million people wearing them in the United States.

Minor damage to the eye is common while serious damage is uncommon. It is important that these problems and complications which are medical problems receive medical diagnosis and medical treatment.

The following consideration should be given to the prevention of hazards of persons wearing contact lenses:

1. Contact lenses should not be worn in the presence of bacterial, viral, or fungus infections of the ocular tissues.

2. Wearing contact lenses should be de-

ferred or discontinued until after any injuries to the ocular tissues have healed.

3. Lenses should not be worn in the presence of filtering areas of the anterior segment which communicate with the inner eye.

4. Defective lenses should be corrected.

5. Poorly fitting lenses which damage the ocular tissues, and especially those lenses which rest in a fixed position across the limbus without movement during blinking, should be replaced.

6. Lenses should not be worn continuously 24 hours a day and patients should not sleep while wearing lenses.

7. Individuals who have only one eye with vision less than 20/100 without correction should not operate high speed vehicles while using a contact lens to correct the vision to normal. This is to avoid the hazard of unexpected displacement of the lens.

8. The complications of wearing contact lenses and the hazards associated with their use are medical problems which require the medical diagnosis and treatment by a physician. For these reasons patients who wear contact lenses daily should be examined at least every 6 months by a physician who by training and experience is skilled in the diagnosis and treatment of diseases of the eye.

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Changing Patterns Of Clinical Medicine

Jerome Cochran Lecture

Gordon McHardy, M. D.

It is a privilege to deliver the Jerome Cochran Lecture in this, the 69th year since your organization officially recognized the contributions of this distinguished physician, public health organizer and administrator, teacher, and medical parliamentarian. In all medical activities his objective was adaptation of our profession to the requirements of effective health care. He believed the essence of planning lay in being realistic about today while looking for ways to arrange a more orderly and better tomorrow. It seems fitting, therefore, to review the present requirements of health care and methods of future adaptation to them.

In The University at the Crossroads, published in 1946, Sigerist[1] noted the changing role of the physician dictated by society throughout history: "The position of the physician in society, the tasks assigned to him and the rules of conduct imposed upon him by society changed in every period. The physician was a priest in Babylonia, a craftsman in ancient Greece, a cleric in the early and a scholar in the later Middle Ages. He became a scientist with the rise of the natural sciences, and it is perfectly obvious that the requirements put upon the physician and the tasks of medical education were different in all these periods."

Consider the career of Jerome Cochran. He became a student of medicine in the Botanic Medical College of Memphis, "attended two courses of lectures and graduated as a doctor of medicine in 1857."[2] Before graduation, he was aware that the peculiar tenets of the botanic system were untenable; his graduating thesis was a formal argument against some of the doctrines of the school, and his valedictory address was a protest against medical sectarianism. His proficiency and social interest were clearly demonstrated when he encountered political force. A newly elected city administration abolished the Mobile, Alabama Board of Health, of which he was an organizer and the health officer. When the inefficient politically appointed lay board had failed, within a year the Board of Health was revived, and Dr. Cochran accepted reappointment. His activities in the field of sanitation were climaxed by his outstanding contribution on the National Yellow Fever Commission. His career as a medical educator included his professorship of Chemistry in the Medical College of Alabama, and his chairmanship of the Department of Public Hygiene and Medical Jurisprudence at the same school. His recognition of changing medical objectives is reflected in his revision of the Constitution of The Medical Association of the State of Alabama. He anticipated the diverse roles to be filled by the future physician, and he recognized the requirement for "proper organization over the advancement of medical science and medical art." James Cochran was acutely aware of the need of physicians to adjust to the tenor of the time.

Physicians are traditionalists. We have inherited a prestigious position. And we live in relative complacency, in intellectual and professional security. Irvine Page expressed it thus: "Medicine has always occupied a unique place in men's hearts and brains."[3] In our security and contentment, we are averse to any change in status. This resistance has been supported by organizational rigidity against change. We are challenged by such public editorializing as that of *Life* Magazine, which contended that: "The A. M. A., obsessed with its struggle against 'socialized medicine' has been slow to grasp the im-

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mense opportunities implicit in the rising demand for medical care."[4]

Forceful, interrelated influences, developing almost simultaneously, involve economic, political, social, psychologic, and biologic demands for change in almost every activity of man and urgently indicate the need for a revolutionary change in the pattern of medical care. Of primary challenge to our professional survival are the certain sociologic factors in health care:

1. The population expansion, with concomitant extension of life expectancy.

2. Intellectual advancements and affluence of the public, leading naturally to demands for extended health programs.

3. Federalism in medicine, stimulated by Medicare, Medicaid, its present and future extensions along with the regional medical programs.

4. Increased appropriations for the support of health care, research, and education.

5. Expanding medical knowledge, necessitating educational revisions at all levels, and more expedient communication and delivery of latest developments.

6. Rising costs of medical care and chaotic fragmentation of services, emphasizing the need for coordinated facilities and organizational activity.

The Doctor Shortage

Medical manpower is crucial in all these changes. Recognition of an increasingly critical shortage in manpower and of the need to modify our concept of medical care from that of an art to that of a science prompts my attempt to analyze our present situation and to make suggestions for adapting to the rapidly changing scene.

Consumer Demand. Continued population increase seems inevitable. Family planning measures are being compensated by survival of the newborn. The health of the youth is sustained by prophylactic control of major infectious diseases. Longevity is potentiated by more specific forms of treatment for diseases, rehabilitation, and possibly organ transplantation.

Education and affluence bring recognition of, and demand for, the benefits of extended health programs.

Federal medicine was previously restricted to the Veterans Administration, the Public Health systems, the Armed Forces, and the division of Health, Education and Welfare. The advent of Medicare and Medicaid marks the beginning of a legislative trend to satisfy the demand for health care as a human right, not a privilege. Legislative measures ready for action include the expansion and permanent establishment of the regional programs, a massive renal disease project, renewal and expansion of Hill-Burton activity, Health, Education and Welfare reorganization, Hill-Harris and other support for the development of group practice facilities. Programs for the urban poor and for pollution control are among ancillary projects. The potentials are unlimited, since political powers are inclined to satisfy consumer desire.

The insurance industry is stimulated to provide "adequate coverage to all the employed," but this is possible "only with the help of all medical, hospital, and other health care groups to hold the cost of care to a reasonable level which the premium payer will be willing to pay." The objective is to leave "no vacuum for the government to move into."[5]

The Coggeshall report recommends increased enrollment in medical schools and reorientation of curricula. Medical schools are likely to get federal and other financial support as an incentive to shorten courses, alter curricula to permit more expedient achievement of specific objectives, enlarge class sizes, and augment the output of doctors. Obviously, the measures projected can only partly compensate for the increasing deficit,[7] and other solutions must be sought. A conservative estimate predicts a consumer increase of 25 per cent with a physician (producer) increase of 19 per cent within the next de-

cade.[7, 8] This ratio will be unfavorably influenced further by anticipated governmental programs as well as medical and drug discoveries.

Aside from our national problem, we are siphoning off physicians from the developing nations in direct opposition to our socioeconomic obligation to these countries. It is generally agreed that the most practical solution to the problem is increased production of American physicians. Toward this objective a dual project is proposed: (1) creation of a large paramedical task force and (2) reorganization of the distribution of medical care to a scientific directive category, with relegation of the intimate patient-physician relationship to obsolescence.

Allied Health Professions and Services

Programs have already been established to train and test the potential efficiency of paramedical aides or clinical associates. Certain functions and responsibilities could be delegated to such aides without jeopardizing the level of patient care. I am not referring here to existing categories wherein personnel shortages have already been emphasized.[9]

The approach I wish to discuss is not, however, new. Adequate experience in various fields has already proved its practicability. Pediatric aides at the Medical School of the University of Washington have functioned well. The performance of medical and surgical corpsmen in the Armed Forces has been laudable. Orthopedic aides at San Francisco's Presbyterian Medical Center have freed physicians for more exacting duties. Skilled nurse-midwives of Kings County and Cumberland Hospitals in New York have assumed prenatal, delivery, and postpartum responsibility in normal pregnancies. Optimetric refraction by aides is relieving the ophthalmologists for more demanding responsibilities. The performance of nurse-anesthetists under supervision of anesthesiologists has been well accepted. The Duke Plan fostered by Eugene Stead[10] and supported by the Josiah Macy, Jr. Foundation has initiated a three-year program with emphasis on effectiveness, and abbreviated curriculum, and inexpensiveness. Emphasis on the supportive potential has been expressed by George Harrell[11] in his address at the White House Conference on Health in 1965. A possible source of candidates is the half of the 16,000 applicants to medical school who were rejected because of space limitations; an organized effort to interest these people in such careers should be made.

Our professional trial and endorsement of the use of such aides will lead to acceptance by their patients and to our mutual benefit. Such careers must be made attractive by expansion in scope and by elevation in status to clinical associate. Creech[12] envisioned their responsibilities to include initial screening of patients, providing care for minor medical problems, arranging for diagnostic procedures, performing resuscitative care to patients with major illnesses or injuries, and performing preliminary examinations of the seriously ill. The Allied Health Professions Personnel Training Act[13] should include support for development of centers to recruit, train, and retrain such associates. Problems of accreditation for certification will arise as a prelude to removing concern over competency and medicolegal responsibility.

Nursing care must also be expanded. The efforts of the American Nursing Association to establish university-based diploma schools will supply personnel for supervisory nursing positions. Adequate subsidization of hospital based diploma schools where adequate clinical training would be emphasized is imperative to supply enough clinical practicing nurses. The "nurse" would then resume her clinical duties, and the added prestige of the title would attract students and re-establish this disappearing profession.

Distribution of Medical Care

Group Practice

Acceptance of group practice plans as a partial and temporary solution is anticipated. The A. M. A. now shows interest in promoting group practice and recently sponsored a

conference on the subject. The Bureau of Health Manpower, U. S. Public Health Service, reporting a current shortage of about 50,000 physicians, has suggested that the best estimate of health care needs is in the ratio of physicians to population served under group practice plans. Instruction of medical students in programs based on group practice is being offered at four major medical schools (Howard, Yale, Duke, Johns Hopkins). Labor has added its endorsement (American Federation of Labor and Congress of Industrial Organizations Council). Former Secretary of H. E. W., the Honorable John W. Gardner, held a conference on group practice at the University of Chicago in 1967 after issuance of the Gorham report, which among other recommendations, encouraged development of the group practice of medicine. The conference director, John W. Cashman, attributed the conference to recognition of "the crisis in cost and the crisis in disorganization in the delivery of services."[14] These were among the recommendations:

1. Interdisciplinary forums, attended by private physicians and ancillary aides, union officials, lawyers, economists, and representatives from medical schools, insurance companies, Blue Cross-Blue Shield, and prepayment plans, management, and federal, state and county agencies.

2. Federal legislation to assist medical schools to establish group practices for teaching purposes and delivery of health services.

3. Federal enactments to overcome existing legal restrictions on group practice.

4. Removal of Internal Revenue tax rulings disadvantageous to group practice.

The implication is that group practice may be the central core for the salvation of the economic structure of medical services. Conservation of manpower, utilization control, training efficiency, organizational unity, and cost control are among the utopian concepts built into such a self-contained and possibly prepayment unit. Only through cooperative effort and unified organization can cost control be achieved.

In the more distant future, group practice may be the screening unit for out-patient and prophylactic health care, rehabilitation, and convalescence, with a new core established in the medical center complex.

In an expansive concept of future unproved use of medical manpower and facilities, Russell Lee[15] would have the physician provided with an assistant who has "academic background training and on-the-job experience." He indicted our present hospitals for their obsolescence. He advocated the creation of community centers for health care with an expanded hospital-based group practice, supplemented by screening and diagnostic units as well as convalescent, rehabilitative, and continuing care units. Special institutes for mental and related illnesses, for geriatric and other chronic diseases would complement the unit, along with ancillary housing, training, and nursing facilities.

Creech,[12] in his concept of future medical curricula, advocated system-oriented institutes patterned after the N. I. H., with system specialists in a ratio of one to 10,000 patients, supplemented by general specialists in a ratio of one to 5,000 patients and by clinical associates in a ratio of one to 500 patients.

Education

Much of this discussion centers in modernizing the organization and systemizing the technical services in teaching and practice. Educational standards of our profession are under surveillance. Licensure at the age of 25 years bears little relation to the knowledge and skill of the practicing physician 30 years later. Quality control in the delivery of services, through evaluation of the whole system of communications and standards, is therefore being suggested for the benefit of the public. One of the objectives of the regional medical programs is continuing medical education, with evaluation of the effectiveness of teaching.

We need to become attuned to the electronic age. The centralized laboratory with automated equipment can enhance efficiency

and accuracy. Intensive care units with extensive monitoring devices, coupled with computers, promise early detection of abnormalities and their automatic correction. The potential value of the computer as a source of storage, retrieval, and calculation is inestimable.[16-19] Physicians should accept and applaud automated processing of the great mass of new information that will be available to us. Engineers are solving the mechanical and manipulative problems more rapidly than we are resolving the problems of acceptance and incorporation of the computers into our everyday practice. These measures of increasing productivity must be embraced.

In this discussion of medical manpower, I believe that I have laid an adequate foundation for these rather startling but plausible predictions for our profession's survival in the near future:

1. Despite the desirability for an intimate patient-physician relationship, the practice of medicine will have to be depersonalized to provide a quality and quantity of medical care compatible with scientific advance.

2. The history, diagnostic procedures, and parts of the physical examination, as well as monitoring of vital functions will be performed automatically and interpreted by computer system.

3. Physicians may become geographic full-time associates of the medical center complex, within which they will have adequate technical, electronic and consultative assistance and where comprehensive medical care will be available on a prepaid basis, but probably partly under federal subsidy.

I believe that we are on the threshold of togetherness of the Gown and Town components of the profession as medical schools become involved in community medicine and look to practicing physicians for the source of residency training facilities.

I believe that the medical profession can and must participate more vigorously in continued analysis of needs, in development of data, in stimulation, creation, and evaluation of programs for quality health care to all members of society.

I believe that we need greater understanding and more flexibility in this period of inevitable change. Only the direction of the changes are alterable in terms of analysis, control, and intelligent application. We must adapt to new climes in fulfillment of our obligation to serve the social component of our science.

I believe the tremendous accomplishments in organ transplantation and cancer chemotherapy will not be frustrated by any departure from moral, legal, or ethical patterns adhered to by the profession in other dramatic advances in surgery and chemotherapy.

I am honored to be added to the list of distinguished Jerome Cochran Lecturers. Among these, I find four of my teachers, Drs. Elliott, Matas, Owens, and Ochsner. The preeminence of these physicians and the others who have been so honored compliments The Medical Association of the State of Alabama in its recognition of Jerome Cochran.

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Southern Medical Association Plans Star-Studded Program

A particularly interesting program has been prepared for the 62nd annual meeting of the Southern Medical Association, to be held in New Orleans Nov. 18-21, bringing distinguished specialists from all over the country to read papers, make lectures, and conduct panels.

Among the visitors and their subjects are: "Diabetes and Obesity" by Dr. Buris R. Boshell, Birmingham, Ala.; "Clinical and Pathologic Aspects of Neuromuscular Disease" by Dr. Kenneth R. Magee, Ann Arbor, Mich.; "Urinary Tract Changes in Pregnancy" by Dr. Richard F. Mattingly, Milwaukee; "Management of Chronic Corneal Ulcers" by Dr. Arthur G. Devoe, New York City; "The Doctor's Role in Death," by Dr. Doris A. Howell; "Low Back Pain: Diagnosis by History and Physical Examination" by Dr. Rene Cailliet; and "Factors Influencing Survival Rates in the Treatment of Cancer of the Colon and Rectum."

"Shock and Trauma" is a panel discussion that will feature a joint meeting of the Sections on Surgery and Plastic and Reconstructive Surgery, with which there will be a closed circuit color television program. And another panel discussion on "Surgical Emergencies in the Newborn" will include a paper by Dr. Edwin I. Smith of Oklahoma City on "Pitfalls in the Surgery of the Pre-Pubertal Female Genital System." This will be followed by a joint meeting of the Sections on Surgery, Pediatrics, and Plastic and Reconstructive Surgery.

A closed circuit color television program on Kidney Transplantation will feature a joint meeting of the Sections on Radiology, Pediatrics, and Urology, and the guest speaker will be Dr. John T. Grayhack of Chicago.

Subjects included in the four-day meeting are Allergy, Anesthesiology, Dermatology, Gastroenterology, General Practice, Gynecology, Industrial Medicine and Surgery, Medicine, Neurology and Psychiatry, Obstetrics, Ophthalmology, Orthopedic and Traumatic Surgery, Otolaryngology, Pathology, Pediatrics, Physical Medicine and Rehabilitation, Plastic and Reconstructive Surgery, Proctology, Radiology, Surgery and Urology.

Meeting conjointly with the Southern Medical Association will be: American College of Chest Physicians, Southern Chapter; College of American Pathologists; Flying Physicians Association; Radiological Society of North America; Southern Gynecological and Obstetrical Society.

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This endeavor has been warmly endorsed by the American Nurses Association and other professional organizations. We feel sure that such a program, bringing skilled nursing care to the bedside of the cancer patient, will be enthusiastically received by the medical profession.

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Senra del Valle and his associates[1] conducted a study of 477 children with diarrhea, most of whom were hospitalized with the disorder. Lomotil, used in 407 of the children, shortened the duration of the diarrhea.

Grinszpan, Goldstein and Divito[2] used Lomotil in 20 children with diarrhea and also reported a prompt disappearance of diarrhea. Harris and Beveridge[3] in a double-blind study of 50 children with diarrhea, however, found no clear pattern to suggest that Lomotil influenced the course of the condition.

Michener, Brown and Turnbull[4] added evidence supporting the beneficial effects of Lomotil in 80 children, concluding that Lomotil was highly useful in controlling abdominal cramping, diarrhea and hypermotility.

Children: Total Daily Dosage

3-6 mo. . . . ½ tsp.* t.i.d. (3 mg.)
6-12 mo. . . ½ tsp. q.i.d. (4 mg.)
1-2 yr. . . . . ½ tsp. 5 times daily (5 mg.)
2-5 yr. . . . . 1 tsp. t.i.d. (6 mg.)
5-8 yr. . . . . 1 tsp. q.i.d. (8 mg.)
8-12 yr. . . . 1 tsp. 5 times daily (10 mg.)
Adults: . . . . 2 tsp. 5 times daily (20 mg.) or 2 tablets q.i.d.

*Based on 4 cc. per teaspoonful.

Maintenance dosage may be as low as one-fourth the initial daily dosage.

References:

1. Senra del Valle, A.; Linfante de Rufinelli, E. B.; Brumetti, E., and Rossi, R. H.: El chlorhidrato de difenoxilato en las diarreas infantiles, Sem. Med. (Buenos Aires) *127*:475-484 (Oct. 4) 1965. 2. Grinszpan, I. L.; Goldstein, A., and Divito, J.: El chlorhidrato de difenoxilato en las diarreas infantiles, Sem. Med. (Buenos Aires) *125*:758-763 (Aug. 27) 1964. 3. Harris, M. J., and Beveridge, J.: Diphenoxylate in the Treatment of Acute Gastro-Enteritis in Children, Med. J. Australia *2*:921-922 (Nov. 27) 1965. 4. Michener, W. M.; Brown, C. H., and Turnbull, R. B., Jr.: Ulcerative Colitis in Children. II. Medical and Surgical Therapy, Amer. J. Dis. Child. *108*:236-242 (Sept.) 1964.

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"State May Control Disease or Violence— But An Informed Public Must Erase It," Brewer

A parallel between violence in the streets and disease in the communities was drawn by Gov. Albert Brewer in his speech before the Alabama Tuberculosis Association in Mobile.

In World War II, when the differences between our country and the communist world were more keenly evident, Frederick Lewis Allen, distinguished editor of Harper's, spoke admiringly of ours as "the Unsystematic American system," and felt that our strength for good lay largely in our "wide and proliferating assortment of voluntary institutions." These organizations are as "consecrated to the idea of public duty as governmental ones can be, but provide at the same time vastly more diversity and flexibility of approach than could be harnessed in any other way," Allen wrote.

The meeting at which the Governor spoke commemorated the 54th anniversary of the founding of the Alabama Tuberculosis Association, and the 40th anniversary of the founding of its component, the Tuberculosis and Health Association of Mobile County. The latter and host organization was praised by the Governor as epitomizing the voluntary movement in this country.

Founded by women, the Mobile organization placed its primary emphasis on children, as the place to start the eradication of tuberculosis. "If," they said, "we could but rear one generation of children, free from the infection of the disease." Brewer praised this dedication not only in Mobile but in the 66 other county organizations at war on tuberculosis and other respiratory diseases, their efforts financed solely by the annual Christmas Seal Sale; an organization whose "views and petitions are listened to with respect because in all its long history it has never appeared before committees of the Legislature in its own selfish interests but always solely in the interest of the unfortunate victims of tuberculosis, present and future.

Just as centralized government threatens to erase "states rights," so centralization is threatening the effectiveness of the voluntary agencies, Gov. Brewer told his Tuberculosis Association audience. Then he added:

"Many who oppose or belittle the emphasis some of us have placed on States Rights do so by saying, Oh, you speak of State Rights, while you should be talking about State Responsibilities. And they say, states—or at least the Southern States—never assume their responsibilities. Only the centralized

establishment has the power. the integrity, the interest in the welfare of mankind they say, to accept social responsibility.

"Let us examine this matter in the light of the history of the Alabama Tuberculosis Association in particular, and the State of Alabama in general.

"The first premise is correct. The Coin of Liberty has two faces. On one face are rights, on the obverse are responsibilities. The coin cannot be sliced in two.

"A fundamental doctrine of our philosophy of government has been that the powers not specifically conferred by our Constitution on the Federal establishment are retained by the Sovereign States. Among such powers not specifically conferred, or rights if you prefer to use the term, is the protection of the public health. Has Alabama accepted and discharged the responsibilities which go with this particular state right or power?

"You know very well it has, and magnificently. I am not here to cite statistics, to bore you with a long recital of tables of declining mortality from the various preventable diseases, notably including tuberculosis . . . But to give a few: Last year, there were *two* reported cases of polio in Alabama. There was *one* reported case of diphtheria and *one* reported case of typhoid fever and *no* reported cases of malaria. As recently as 15 years ago, there were 500 reported cases of polio; more than 300 cases of diphtheria.

"These achievements were brought about not by chance; not by just an improved standard of living. They did not result from such simple things as larger automobile engines, bigger electric refrigerators and more numerous color TV sets. They were brought about by an active, organized full time public health facility and by the insistence and encouragement of voluntary associations like the tuberculosis association in the adequate maintenance of such facilities.

"Nothing I have said is intended to belittle our debt to the dedicated leadership and advice and counsel of the Public Health Service (much of its recent advancement due to a native Alabamian who served as its Surgeon General); our debt to agencies and instrumentalities as the Medical Corps of the Army of the United States (Alabama would not have been free from yellow fever for more than a generation had it not been for such men as that other native Alabamian, Gen. William Crawford Gorgas, of that corps).

"Indeed, no man, and no state is a region unto itself. There is no dedicated medical scientist seeking the truth in any laboratory in the world, however remote, to whom Alabama is not deeply indebted.

". . . Tuberculosis, once called Captain of All the Men of Death, while driven back, still represents a tremendous public health problem in Alabama as elsewhere."

Individuals, the legislature, governmental institutions and voluntary agencies have coordinated their efforts to conquer disease, and in this instance tuberculosis, so that today "there is not a man, woman or child, re-

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gardless of race or creed or station in life, in any of the 67 Alabama counties, needing and desiring hospital care for tuberculosis for whom such care is not freely available."

There is still more to be done, he said, and "I am sure the Legislature will welcome the advice and counsel of the Alabama Tuberculosis Association. . . For, although we are united in the belief that eradication of tuberculosis is scientifically possible" it has not been accomplished in the most conspicuous areas; "within the past five years, there have been two confirmed newly reported cases of leprosy in Alabama."

The Governor saw paralleling objectives in the eradication of tuberculosis and the preservation of "private enterprise," underscoring the role of private enterprise in the crusade against tuberculosis.

"We in Alabama are proud of the fact that perhaps the real beginnings of the care of tuberculosis victims in our state over half a century ago, were brought about when through private enterprise, expressed in the good old competitive American way, some individuals interested in the voluntary tuberculosis movement, enticed away from the then great center of tuberculosis control in the South, Asheville, N. C., one of the early pioneer specialists in tuberculosis nursing.

The enticement was a bigger job to do at a higher pay; although it would be an insult to her memory to infer that the last consideration counted for much, when compared to the first.

"Eradication as contrasted with the word control brings me to my last and most important point. There is something higher than states rights—individual rights. There is something higher and beyond the responsibility of states individual responsibility.

"Let me bring an illustration from the streets of the cities of America of 1968. The state can—although perhaps at great cost—*control* violence. The *eradication* of violence

(Continued on Next Page)



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depends not merely on courts of law and enlarged police forces, but upon the education and upon the civic and social responsibility of individual human hearts.

"A state can *control* tuberculosis. The *eradication* of tuberculosis will depend upon the education of the individual family not only to support with its influence and its taxes the efforts of the state. But upon its acceptance of its responsibility for the protection of its own children from infection with tuberculosis. Who can bring about this dual education responsibility? Not the state. Private enterprise. You, the voluntary tuberculosis associations of Alabama."

Books Of Professional Interest

THE PERSON IN THE WOMB, by N. J. Berrill, Ph. D., Dodd, Mead and Company, New York, 189 pages, indexed—$5.

In the four pages of his opening chapter, Dr. Berrill, an internationally-known development biologist now at Swarthmore, summarizes both the content and the purposes of his remarkable book. In the opening paragraph he establishes his subject, Man, as:

". . . a relatively late comer on this aging earth. A poet has said that he is a spirit and symbols are his meat. He has been called a large, naked byped with a big brain. In fact he is many things, depending on how narrow or broad or deep the point of view. He is an organism, in common with every living thing upon this planet. Watery, sensitive, responsive and self-propagative. Above all, transient, with a beginning and an end, from which comes our joy of life and our despair. He is also a fish out of water, with bottled-up juices inside a dry skin, forever coping with the down-dragging force of gravity, levering himself along with muscles and bones. And he is a mammal, one among many. As such he, or more particularly she is a reproductive device that produces young alive and requires sexual intercourse to start the process—setting the stage for family life."

On an intermediate paragraph he brushes aside the stupidity of "equality" with a sentence: "Every person needs to know, and to know as a child, that he is the only one of his kind and that his companions are each different in ways of their own and demand respect for what they are;" and sets the pace of the book with other sentences of the same paragraph: "Self-creation and self-fulfillment are the crying needs of every person. Quality of body, mind and spirit is paramount. If this be the goal for every man, it shows a narrow path, and it is doubtful whether a rampaging, voracious multibillion human herd can squeeze along it." Then in a concluding paragraph he poses the rule the book will develop:

"The person is sacrosanct, once the person has come into being . . . Before birth there is little more than potential, no real actuality except for what might become. But with awakening at birth, the present and the future is upon us all. In body and mind and soul the human being reaches for new life, gathering all experience for the sake of being and of growth. Whatever or whoever tramples upon the spirit is evil. It is the human birthright to be born whole in body, brain and senses, to be nourished materially, emotionally and mentally and to stand in a world where there is space and beauty and where the essential dignity of the individual is known to all. And by the same token no child must be born without hope, no woman must bear a child against her will and the sons of men must not overwhelm the earth."

From there, this book goes through the miracles of conception, birth, the span of individual existence and death, in a book that is readable, thought-provoking, poetic and profound.

—W. J. M., Jr.

Role of Public Relations Vital to Medicine, Jim Reed Tells Trustees

In 1847, when the diploma mills were grinding, when M. D. degrees could be bought for a price, and when formalized medical education was practically non-existent, the American Medical Association came into existence. In fact, that is why AMA was born, Jim Reed, director of communications of AMA, told the August meeting of MASA's Board of Trustees.

"AMA and medical education in this country have grown up together. . . There was a time, years ago, when physicians went abroad for their postgraduate medical education. Today the physicians are coming here and in great numbers . . . because they want the best medical education available.

"Physicians of America through the AMA Education Research Foundation contribute about $5 million a year to help finance medical schools in this country."

Defining communication as public opinion, he declared that public opinion is the most "powerful determinant in . . . the social, economic and political course of this nation," adding that if "the medical association wants to retain its system of incentives and freedoms of practice, which you believe is the best for the public, then you must shape this public opinion.

"Freedom and responsibility go hand in hand. They always have. And if we fail to see the dimensions of our responsibility and to measure up to them, then we are in for threats of restrictions and controls on policing. And there is always someone around to say there ought to be a law. . .

"Public relations is very simply getting credit for the good you do. Doing good is up to you gentlemen, in your practice and through the programs of your county and state medical associations. Caring for the patient, practicing good medicine, handling fees and their payment properly, showing responsive and definitive leadership on problems, some of which are just beginning to emerge, are all a challenge to public relations, and



Jim Reed

getting credit for it complete the job of communications."

The AMA Director of Communications then detailed facets of his job including publication of AMA News (a weekly tabloid of 330,000 circulation, going to every physician in the United States, whether or not he belongs to AMA), Today's Health (a monthly consumer-type magazine, of 700,000 circulation, boasting frequent reprints in Readers Digest "that jumps the readership from our 700,000 to their 15,000,000"), the news section of JAMA; the department of radio, television and motion pictures "which produces all the non-scientific films for AMA," a film library of more than 400 scientific films on clinical medicine; AMA's Health-Tip-of-the-Day, used on 2,600 radio stations; and in addition, taping programs with physicians who are experts in their fields, arranging interviews for AMA officers and placing them on such programs as "Today's Show," Johnny Carson, Mike Douglas, Walter Cronkite, Art Linkletter, and others; five-minute vignettes of medical discoveries, an exhibit department, a photo department, a department for "Litera-

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ture Counseling," another of Program Services for Women's Auxiliaries and the Medical Assistants Association; a booklet, "Winning Ways With Patients;" a series of posters, and the like.

There is a PR institute each August. There is an Advisory Committee. Then there is the matter of handling 1,500 phone calls a day, receiving 35,000 letters a week and sending out 40,000.

A sharp disparity among state medical associations in their relations with graduating medical students was discussed in detail by Mr. Reed. He cited Illinois and Iowa as contrasting illustrations. In Illinois almost 4,000 physicians do not hold membership in the state society, while in Iowa, a "state that makes an annual contact with all the interns and residents, 95 per cent of the eligible physicians are members of the Iowa Medical Society and AMA."

He cited ways in which some states stimulate interest in their state association. Students in Texas medical schools receive special attention on a number of days, such as Medical Students' Day at the University of Texas, when medical organizations, HEW, and other groups present programs. Mississippi sends copies of its journals to all medical seniors, interns and residents. California prepares comprehensive kits and brochures, telling "the facts of life in medical practice, covering insurance and economics, administration, management, and the CMA placement service."

In the concluding paragraphs of his talk, the speaker reported on a survey of state and county medical society executives, asking questions:

"What have you found to be the most effective method of communicating with your physician members?" The answers: (1) first class letters, (2) newsletters, (3) their bulletins, (4) special meetings, and (5) their society's regular journal. In addition, some used the telephone and personal contact.

What, they were asked, is "the most effective Public Relations program your medical society can sponsor?" The answers mentioned most were those of direct benefit to the public, such as: mass immunization, diabetes detection day, venereal disease campaigns, measles immunization programs, cancer detection, cancer tumor clinics, glaucoma detection days, etc.

Among the most critical PR problems mentioned were (1) physician-patient relationship, (2) cost of medical care, and (3) the shortage of physicians.

In conclusion, Reed pointed to an array of a hundred different publications covering a wide range of subjects that would be helpful to physicians with problems to solve, ranging from the 970-page book on medical terminology to a 56-page work on designing and planning a medical office, from a 360-page book of selected questions and answers from JAMA to a handbook for the primary physician.



Politically Speaking

By Dale Alford, M. D.

Little Rock, Arkansas

It is a distinct honor and I consider it a high privilege to have been invited to address this distinguished society of leading surgeons from every section of Alabama. All of us here share a common bond in having taken the Oath of Hippocrates; We share a common bond in being a part of that section of our country lovingly called by us as "The Southland"; and we share a bond as small businessmen since we are one of the few remaining independent professions still loyal to the principles that made America the healthiest, wealthiest, and most powerful nation in the world in the shortest period of time throughout all the world's history. You and I, today, are "independent Americans."

One of the crucial questions which confronts us is just how much longer will we be truly independent. One of my forebearers originated in Virginia and later fought with General Andrew Jackson at the Battle of New Orleans. He was a great admirer of General Jackson, as I have been since I passed through the Huckleberry Finn and Tom Sawyer stage. Jackson was an independent American who took a keen interest in the affairs of government. This tradition continues with many of us.

Those who are articulate on matters politic today must be prepared, as Jackson was, to take up arms against a sea of trouble. Jackson took up the battle of the pioneers of the West and the South and the voiceless destitute of the big cities. For that, like Thomas Jefferson, he was called a rabble rouser. Old Hickory fought the same battle the writer of the Declaration of Independence fought—"The Control of Government by a Small Minority Instead of by a Popular Opinion Duly Heeded by the Congress, The Courts, and the President."

A few of us have often spoken out against the selfish minority that would socialize this great government of ours, but we have a great handicap, i. e., A Doctor's Degree in Medical Science; so since this is the year 1968 and since this is the decade of downgrading the doctors, when we speak up in opposition to the takeover of this great government by a selfish minority, as did Andrew Jackson, we are told that we should not stand up and speak out against dictatorship *Because We Are Doctors!*

My Fellow Americans, what on earth goes on here in the land of the demonstrator and the home of the hippie? What is wrong about a man who spends twelve years of study after high school improving his mind in the field of science having an opinion about affairs politic any more than the man who studies criminal law or the stock market or pedagogy or journalism, or court house politics?

What is wrong about a doctor having an opinion about anything other than a pill? There is nothing wrong about it, but those who say it is wrong are those prating, political parasites who are afraid of the doctor-businessman because the doctor has been the last *really* independent businessman. What *is* right is that a doctor who is worth his salt will not sell out his city or county or state or national government to the political racketeers! ! ! ! ! The physicians of the United States are in a life and death struggle against a minority in national government today who are determined to politicalize the health care of all our people.

One of the apostles of Communism stated that the keystone in the arch of total Socialism is socialized medicine: Isn't this one statement alone sufficient for any intelligent, educated patriotic American to be aware of the symptoms of the design of a socialistic minority among us today? The symptoms are easily recognizable—"recognize Red China," "discrimination," "world peace through world government," let them kill our boys,

Presented at the Annual Meeting of the Alabama Academy of Otolaryngology and Ophthalmology, April 17, 1968, Birmingham, Alabama.

but "stop bombing." We have all heard the word communism so much that we are sick of it, but by placing our heads in the sand in ostrich fashion only makes us more vulnerable to minority control. Whether the cocktail party pinks like it or not, communism is at the root of all our troubles in America today.

For just a brief moment let us take a look at history. When President Washington was prayerfully groping his way in the organization of our republic he questioned whether government would not be most safely conducted by the minority of education and of wealth, but immediately Jefferson recognized that such control would result in the destruction of a sound democratic system so he pleaded that the government should be more responsive to the public will. In 1968 the granting of such privileges to a minority whether other than the educated and other than the wealthy will, in the words of Jefferson, "result in the destruction of a sound democratic system."

We in the medical profession today are simply pointing out that when doctors are responsive to the people through the private enterprise system the finest health care in the world is made available. The history of governmentalized medicine in Europe is one of doctors being responsive to the will of the politicians rather than to the will of the people. All of us recognize the health needs of our people and these needs must be met. But let us meet these needs by continuing the American system of rewarding the hard worker, giving of our all to the unfortunate, and without malice, exposing the shirker. This system will maintain the moral integrity of democracy and the republic!

We can continue this theme of noble thoughts on a high plane but if we mean what we say and are determined to achieve results, then, unfortunately, we must play the game of politics on the playing field of the politicians. This is not to say, and this is certainly not to leave the remotest inference, that there is to be a compromise of principle. Truth is still truth and honor is still honor. Results can be achieved, however, without resorting to the lower levels of the demagogue and the petty professional politicians.

As physicians, to know how to treat a certain disease, you must study the cause of the disease, or the etiology, and every other phase, including the handling or the treatment of the condition. If we, in medicine, are to preserve the superior practices of private enterprise, we are forced to study politics. The study of politics is the study of influence and the influential. The influential, of course, are the ones who get what they want and those who get the most of what they want are the "elite" in politics and the rest are relegated to the masses. In fighting a political battle, as in any other conflict, we must analyze that which we are fighting. There is skill in political organization, in the church, in medicine, in the large corporation, as well as in government. Political influence is really a pyramid. For example, the hierarchy of the Roman Catholic Church has been cited as an example with, at one time, having 1,578 bishops, 245 archbishops, 55 cardinals, and, of course one pope. Methodist, Episcopal, and others have a similar pyramid.

The Communist Party in the Soviet Union comes quickly to sharp head in the political committee of nine or ten members. In our own government the presidency of one, the senate of 100, and the house of nearly 400, is an example of the pyramid, but within this looser structure special influence has more recently been taken by nine men, the supreme court of the United States. Positions of top influence are quite susceptible to violence. One study showed that 31.9 per cent of a series of 423 Monarchs of different countries and different periods died by violence; 40 per cent of the presidents of the Republic of Bolivia died by violence. Approximately 12.1 per cent of the presidents of the United States and of France and 9 per cent of the Catholic Popes died by violence. There are differences in influence and there are marked differences in proportion of income among

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(Continued from Page 453)

our people. The values of safety and of income and their differences are simply pointed out as illustrative findings in political analysis. One form of analysis would be to classify people according to their skills.

Some men have simply come to the top of the political pyramid through their fighting skills. We don't recommend this, but if we are to look at the facts and be practical, we only have to look at recent history. What about Hitler, Mussolini, Stalin, Mao or Ho Chi Minh? They were politicians but this doesn't mean we have to be like them, for there are other skills through which people can be led than by violence. As for myself, I am neither a dove nor a hawk—I hope I can be classified as just a plain American, bold enough to stand up and speak out for America, and brave enough to wear the uniform of my country when she is threatened from within or from without. Since the press is using a symbol from the Audubon Society to designate political ideology, let us just remain dedicated and responsible followers of the *American Eagle*.

If we wish to influence local or national legislation affecting the health of our people, we must develop some skill in political organization. Some of us can be influential through oratory, some through journalism, some through financial ingenuity and some through old-fashioned political contact—person to person interest in the welfare of all people, rich or poor, social elite or political elite.

It is the individual who is not interested in his fellowman who has the greatest difficulty in life and provides the greatest injury to others. Hatred is never ended by hatred. A misunderstanding is never ended by an argument, but by tact, diplomacy, concentration, and a sympathetic desire to see the other person's viewpoint. In short, we can disagree without being disagreeable. This is a skill that our profession must master if we are to be effective in the field of health legislation. It has been well said that the secret of making a woman fall in love with you is to talk to a woman about herself, or for a woman to talk to a man about himself. Gentleness and friendliness are always stronger than fury and force. The mailed fist can have a kid glove.

These are just a few of the skills that must be used in the handling of things in modern times. The socialist propagandists have for years made a play for the lowest class of worker, yet the middle class are the ones who have the skills to run the factories, man the banks, get the greatest yield from their farms and provide the skills that care for the health needs of all our people, regardless of class. Our message should be carried to these people, now. In their hands rest the future course of America. Yes, of course, agitators will come and go, and rise to greatest peaks during fiery crises, but the quiet steady information and organization that you can provide to the skilled middle class will direct the special form of political result which you desire, the preservation of the private enterprise system and the freedom to practice your art and your skills without governmental controls secured by cunning minority manipulators. The true politician learns to use all of the public objects as a means of alleviating the stresses of his intimate environment.

One political scientist states that the politician does not act for the sake of action; he implies that he strives for the glory of God, the sanctity of the home, the independence of the nation, the emancipation of the class. He is concerned only with the deference meaning of objects for his ego. I hope you are getting the point, that to achieve noble ends that unfortunately the true politician must be influenced to use his influence with the influential. The power you may need to help write what we consider are the best health laws for the nation can only come through the powerful politician and through the influential, such as the financier, the journalist, the public utility organization man, the labor union official, the farm organization career executive, etc., etc.

One of the greatest troubles with physicians and surgeons as a whole is that they are most reluctant to be practical and get behind and support their own colleagues when that colleague could be in a position of power or of influence. A practical example in point is simple but it is a good lesson for us as physicians. I know of a case where a candidate for congress, who was later elected, received a $50.00 donation from a $50,000 a year businessman while a neighborhood independent groceryman made a cash donation to the campaign fund of $500.00. When a friend of each of them was an applicant for a rural mail carrier's job and both eligible, which donation do you think carried the most influence? Don't laugh and don't take this example lightly, it takes the three "M'S" to elect people to public office in America. Namely, "Men, Money, and Machines." To influence legislation in your state you must help good men be elected to the office and these good men must have money with which to make a campaign. And this campaign must have an organization to be successful, and this is what constitutes a political machine.

Different results can be obtained by using different methods, but when the state legislature is in session, and when the United States Congress is in session, there must be someone constantly on duty, eternally vigilant, and dedicated to the preservation of private enterprise health practices, thus preventing the smooth passage of restrictive legislation by the politically influential elite. What works is an organization of men supplied with enough money to be effective. Academic political science can give you the political past, but you must be an activist in the political *future* to secure the desired result.

The Federal Government, State Government, and even Local Government seem to be affecting the practice of medicine more and more with each passing day. The changes that have been made relative to health care in the past decade are revolutionary. No longer can we hold back socialistic legislation but, in my opinion, we have reached a point of no return. To prevent further detriment to the proper health care of our country, we must have intelligent planning to cooperate with these governmental bodies without permitting them to become dictators of the way or manner in which we shall practice medicine. We are in a revolution today and it is inevitable that the looters and violaters must ultimately succumb to law and order, else our so called civilized society will be relegated to the mores of the jungle. It is inevitable that powerful political bosses must bow to well ordered campaigns and honest elections, else our so-called democracy will be relegated to gangsterism. It is inevitable that the free wheeling multimillionaires will be curbed in the establishment of tax exempt foundations who fight with your money to promote socialism and cooperate with the communists.

It is inevitable that organized medicine will be regulated further, devoting much of their time to s o c i a l problems. The truth is that we are standing between two mountain peaks of eternity, on the right, the anguished cries of a free society, and on the left the impractical idealists and cocktail party pinks resulting in the sad fact that government is in medical care in America and cannot and will not be forced out. As Doctor R. H. Kampmeier recently wrote, "The sad part is that social planning tends to be political rather than thoughtful. By and large planning is by politicians, social workers, and physicians behind desks who either never developed knowledge of, or have forgotten the unpredictability of the human animal in his demands and in his responses." I join with Dr. Kampmeier in sincerely hoping and praying that knowledgeable representatives of the medical profession—those who know sick people at first hand—would be called upon for advice when the initial stages of planning or legislation are at hand and not at hearings when matters are pretty much a fait accompli. This is definitely too much to expect of the average politician!



pinworms in this school?

possibly, because hygienic measures alone, however meticulous, may not prevent the spread of pinworm infections which are estimated to occur in from ⅓ to more than ½ of all American children from every social level

REMINDER: Because pinworm infections spread easily and quickly in families, schools, and institutions, multiple infections among primary groups seem to be the rule rather than the exception. For successful management, it is desirable to check all exposed members of the family or play group. The *single-dose efficacy* of POVAN makes therapy entirely practical, convenient, and economical.

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ADVERSE REACTIONS: Nausea, vomiting, cramping, and diarrhea have been reported.

POVAN is available in suspension or tablet form. The pleasant-tasting, strawberry-flavored suspension contains the pamoate equivalent of 10 mg. of pyrvinium base per cc., in 2-oz. bottles. The sugar-coated tablets each contain the pamoate equivalent of 50 mg. of pyrvinium base, bottles of 25.

When examination reveals pinworm infection—an increasing number of physicians favor treatment with a single, well-tolerated dose of—

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Four Notable Papers on Calhoun Seminar Agenda

A quartet of important papers, read by four outstanding doctors—one from New York, one from Tulane, and two from Mississippi—and each followed by a 10-minute question-and-answer period, will occupy the afternoon session of the annual Medical and Surgical Seminar, to be held Nov. 13th at the Anniston Country Club, sponsored by the Calhoun County Medical Society.

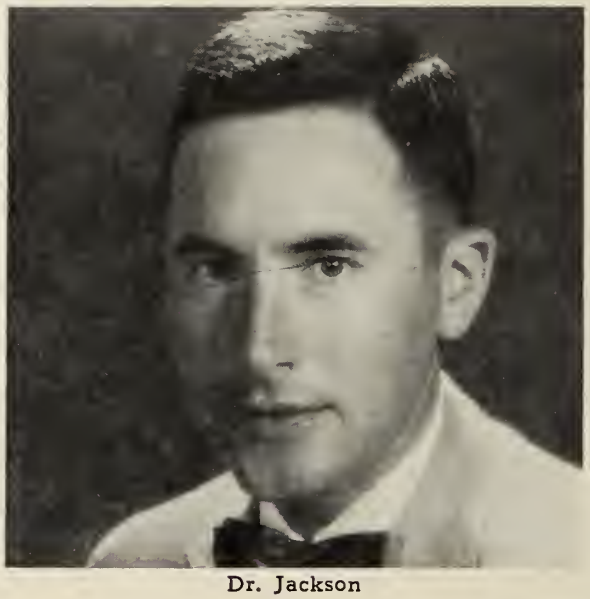
Invitations have been sent to the doctors in the northeast quarter of the State, but all members of the Medical Association of the State of Alabama are invited. Dr. Russell J. Leonard is moderator for the program which begins at 1 p. m. A reception is scheduled for 5:30 to 7 p. m., when the Calhoun Medical Society annual banquet is to be held, with Dr. Tennyson Guyer of Findley, Ohio, as the after-dinner speaker. His subject is "The Personal Touch."

The first paper on the agenda will be by Dr. John J. Jackson, professor, Medical Genetics, University of Mississippi School of Medicine, and is titled "Chromosomes and Clinical Medicines."

Dr. Jackson, a native Missisippian, will dis-



Dr. Barclay



Dr. Jackson



Dr. Butterworth



Dr. Barnett

cuss simplified techniques of sex chromatin determination and chromosome analysis, and how they can provide answers to several perplexing problems in clinical practice. Chromosome analysis, he will say, can confirm a clinical suspicion of Down's syndrome (Mongolism); is helpful in establishing the diagnosis and suggesting the prognosis in other syndromes of multiple congenital abnormalities, 13-15 trisomy, 16-18 trisomy, and the "Cri-du-chat" syndrome.

Dr. David L. Barclay, professor, Obstetrics and Gynecology; professor, Reproductive Physiology, Tulane University School of Medicine, native of Washington state, has as his subject, "Differential Diagnosis of Amenorrhea."

Primary amenorrhea is most often a manifestation of a developmental abnormality of the gonads or embryonic ductal structures giving rise to the uterus and vagina. In contrast to developmental abnormalities of the ductal structures, abnormalities of the gonads are often genetic in origin. Gonadal dysgenesis (Turner's syndrome) due to aberrations of the sex chromosomes is one of the most common causes of primary amenorrhea.

Secondary amenorrhea is often the reflection of a disease process in the endocrine system including primary disfunction of the ovaries. On rare occasions an abnormality of the sex chromosomes may be found in a patient who has menstruated irregularly for several years. Primary emphasis will be placed on discussion of the polycystic ovary syndrome and treatment by either ovarian wedge resection or the administration of Clomid.

"Office Diagnosis of Cardiac Diseases" is the subject of Dr. J. Scott Butterworth, Melville Fellow in Cardiology, Associate Professor of Medicine, New York University School of Medicine. Dr. Butterworth's degrees are from Cornell and Columbia.

Discovery of the stethoscope by Laennec in 1819 was the beginning of present-day diagnostic methods, Dr. Butterworth's paper will say. The development of the electrocardiograph at the turn of the century added impetus and since that time many devices and procedures have forwarded the diagnosis of heart disease. Some remarks will be made about additional instrumentation for office use, but he will caution that, "with all these diagnostic devices we frequently forget the very best methods we have at our command: a detailed history and a thorough physical examination, including careful cardiac auscultation."

The concluding paper of the afternoon will discuss "Refinements in the Clinical Management of Gangrenous Bowel Obstruction," by Dr. William O. Barnett, another native Mississippian, Professor of Surgery, University of Mississippi School of Medicine.

Dr. Barnett divides his paper into ten subheads: Diagnosis, Stages, Restoration of Cardiovascular Stability, Central Venous Pressure, Technical Consideration in Central Venous Pressure Measurement, Pre-operative Elimination of Lethal Properties of Gangrencus Bowel, Endotoxins, Digitalization, Irrigation of the Peritoneal Cavity, and Route of Antibiotic Administration.

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Precautions: Use with caution in patients hypersensitive to sympathomimetic compounds, who have coronary or cardiovascular disease, or are severely hypertensive.

Dextro-amphetamine sulfate: Excessive use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised, especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on the drug. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of preexisting symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dosage and avoid operation of motor vehicles, machinery or other activity requiring alertness. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.
Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness. Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia; the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

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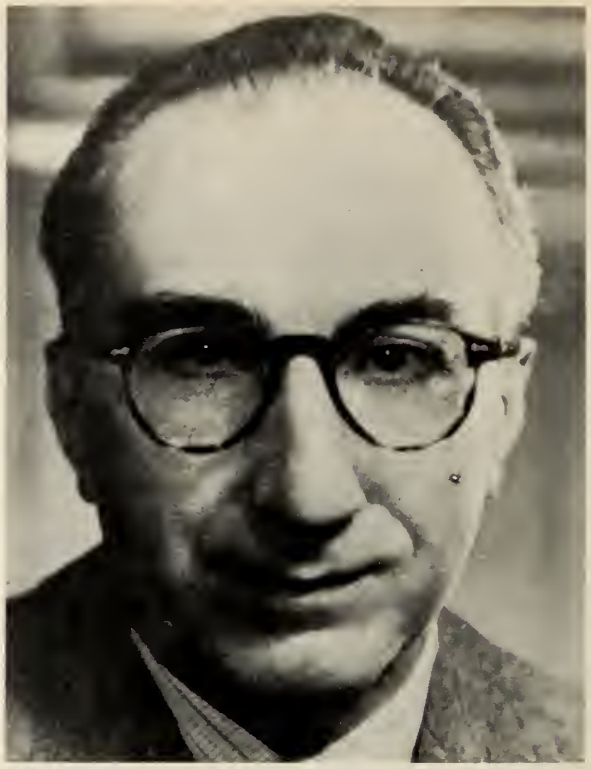
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Dr. Bird



Dr. DeBakey

Michael Ellis DeBakey, M. D., internationally known surgeon whose range of activity includes not only operative technique but also extensive medical research, whose headline-making projects have included development at Baylor of an artificial heart, and Forrest M. Bird, Ph. D., renowned as a lecturer on postgraduate level covering physiology, pathology, biochemistry and medical physics, founder and head of the Bird Corporation and the Bird Institute, creating aviation and medical servo mechanisms, are scheduled speakers at "The Big Meeting" of the Houston County Medical Society to be held Dec. 6th. This annual event always attracts a large number of visiting doctors.



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In the complex picture of moderate to severe anxiety...



there is a new reason for prescribing Mellaril (Thioridazine HCl)

effectiveness in mixed anxiety-depression

Long recognized for its usefulness in the treatment of moderate to severe anxiety, Mellaril is now also known to be effective against mixed anxiety-depression.

Often the symptoms of anxiety states are difficult to sort out—even with the most careful probing. The patient may manifest symptoms of agitation, restlessness, insomnia, somatic complaints. But what of the depression that may be mixed in the total picture? It is reassuring to know that Mellaril may be prescribed—with strong possibilities of success—when there is anxiety alone or a mixture of anxiety and depression.

Before prescribing or administering, see Sandoz literature for full product information, including adverse reactions reported with phenothiazines. The following is a brief precautionary statement.

Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.

Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when necessary.

Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving). Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascular System*—Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers, including Mellaril (thioridazine hydrochloride). While there is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients previously showing electrocardiographic changes. The use of periodic electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. *Other*—A single case described as parotid swelling.

Mellaril®
(Thioridazine HCl)
25 mg. t.i.d.

for moderate to severe anxiety and mixed anxiety-depression

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of pain, stiffness and tenderness...and also a lot of fish.
It might have been different with **Butazolidin® alka**

100 mg. phenylbutazone
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150 mg. magnesium trisilicate

If it doesn't work in a week, forget

But please don't forget this:

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently. Large doses of the alka formulation are contraindicated in glaucoma.

Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Persistent or severe dyspepsia may indicate peptic ulcer; perform upper gastrointestinal x-ray diagnostic tests if drug is continued. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with caution in the first trimester of pregnancy and in patients with thyroid disease.

Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. Patients should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage occur. Make complete blood counts at weekly intervals during early therapy and at 2-week intervals thereafter. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The more common are nausea and edema. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately before or after meals or with milk to minimize gastric upset. Drug rash occasionally occurs. If it does, promptly discontinue the drug. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), or a generalized allergic reaction similar to serum sickness may occur and require permanent withdrawal of medication. Agranulocytosis can occur suddenly in spite of regular, repeated normal white counts. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity angiitis, pericarditis and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.



Dosage in Painful Shoulder: Initial: 3 to 6 capsules daily in 3 or 4 equal doses. Trial period: 1 week. Maintenance dosage should not exceed 4 capsules daily; response is often achieved with 1 or 2 capsules daily.

In selecting the appropriate dosage in any specific case, consideration should be given to the patient's weight, general health, age and any other factors influencing drug response.

(B) 46-070-B

For complete details, please see full prescribing information.

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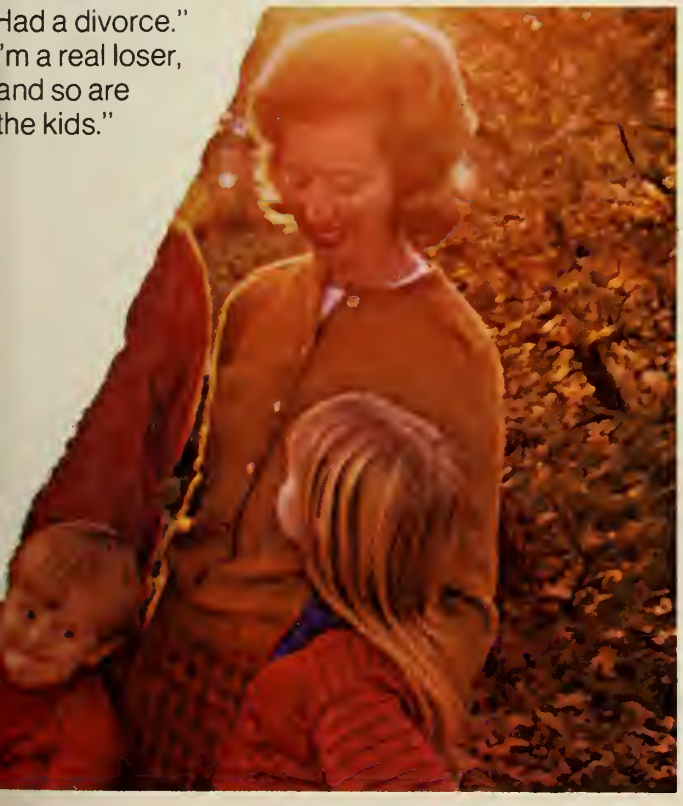
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"Had a fine home and family."



TO-5757

.Forlorn"

Had a divorce."
'm a real loser,
and so are
the kids."



The loss of marital compatibility results in nearly 500,000 U.S. divorces each year.

Depression characterized by untold guilt feelings, grief and loneliness may follow.

When you diagnose depression, Tofrānil may be indicated for relief.

As maintenance therapy during the active phase of depression, Tofrānil can often help prevent relapse.

The use of Tofrānil in patients receiving M.A.O.I.'s is contraindicated. In patients with cardiovascular disease, thyroid disorders, increased intraocular pressure; in those receiving anticholinergics (including antiparkinsonism agents), thyroid medication or antihypertensive adrenergic neuron-blocking agents; and in those in their first trimester of pregnancy–the special precautions listed in the Prescribing Information should be carefully observed.

Toxic reactions severe enough to require discontinuation of Tofrānil are uncommon. However, for complete details, please refer to the complete Prescribing Information.

Turn page for brief summary of Prescribing Information.

in depression

Tofrānil® imipramine hydrochloride
Geigy

in depression





Tofrānil® Geigy
imipramine
hydrochloride

Tofrānil®, imipramine hydrochloride
Indications: Tofrānil is recommended for the treatment of depressive states of diverse psychopathology.
Contraindications: The concomitant use of this agent and monoamine oxidase inhibiting (M.A.O.I.) compounds is contraindicated. Hyperpyretic crises or severe convulsive seizures may occur. Potentiation of adverse effects can be serious or even fatal. An interval of at least 7 days after M.A.O.I. therapy has been discontinued should be allowed before this drug may be substituted. Initial dosage should be low, increases should be gradual, and the patient's progress should be carefully observed.
Warning: Clinical reports have suggested that there may be a risk of teratogenesis associated with the use of this compound during the first trimester of pregnancy. Unless, in the opinion of the prescribing physician, the potential benefits outweigh the possible risks, it should not be used during the first trimester of pregnancy. Cardiovascular complications, including myocardial infarction and arrhythmias, have occasionally occurred in susceptible individuals. Patients with cardiovascular disease should be given the drug only under careful observation and in low dosage.
Precautions: Since suicide is always a possibility in severely depressed patients and one which may persist until significant remission occurs, such patients should be carefully supervised during early treatment. Some severely depressed patients may also require hospitalization and/or concomitant electroconvulsive therapy. Because of its anticholinergic effect, caution should be observed in prescribing the drug for patients with increased intraocular pressure.
In rare instances, transient cardiac arrhythmias have occurred in hyperthyroid patients and in patients receiving thyroid medication when this compound was added to the regimen. Imipramine may block the pharmacologic activity of guanethidine and other related adrenergic neuron-blocking agents.
The drug is not recommended at the present time in patients under 12 years of age.
Adverse Reactions: Dryness of the mouth, tachycardia, constipation, disturbances of accommodation, sweating, dizziness, weight gain, urinary frequency or retention, nausea and vomiting, peripheral neuritis, mild parkinson-like syndrome, tremors, rare cases of falling in elderly patients, confusional states (with such symptoms as hallucinations and disorientation), activation of psychosis in schizophrenics and agitation (including hypomanic and manic episodes) which may require dosage reduction and/or addition of a tranquilizer or temporary discontinuation of the drug, epileptiform seizures, orthostatic hypotension and substantial blood pressure fall in hypertensive patients, purpura, transient jaundice, bone marrow depression including agranulocytosis, sensitization and skin rash including photosensitization, eosinophilia, and mild withdrawal symptoms on sudden discontinuation after prolonged treatment with high doses. Occasional hormonal effects (impotence, decreased libido, and estrogenic effects) may be observed. Atropine-like effects may be more pronounced (e.g. paralytic ileus) in susceptible patients and in those using anticholinergic agents (including antiparkinsonism drugs).
Outpatient Adult Dosage: Initially, 75 mg. daily, increased, if necessary, to 150 or 200 mg. Maintenance dosage may be lower, 50 to 150 mg. daily, if possible.
Geriatric and Adolescent Dosage: Initially, 30 or 40 mg. daily, which may be increased according to response and tolerance. It is usually unnecessary to exceed 100 mg. daily.
A lag in therapeutic response, lasting from a few days to a few weeks, should be expected. When dosage recommendations are already being followed, increasing the dosage does not normally shorten this latency period and may increase the incidence of adverse reactions.
Availability: Round tablets of 25 and 50 mg.; triangular tablets of 10 mg. for geriatric and adolescent use; and ampuls, each containing 25 mg. in 2 cc. for I.M. administration.
(B)R-46-850-C

For complete details, please refer to the full Prescribing Information.

Geigy Pharmaceuticals
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TO-6757



The Month in Washington

From the Washington Office
American Medical Association

Washington, D. C.—The American Medical Association protested strongly against proposed new medicaid regulations affecting payments to physicians and utilization review.

The proposed regulation on physicians' reasonable charges was described as an anomaly in a protest to the Department of Health, Education and Welfare.

In the protest filed with the Department of Health, Education and Welfare, the AMA termed the proposed regulation on physicians' "reasonable" charges as an anomaly because it is based on payments received with no consideration given to the usual and customary fee.

Since medicare payments made by the government are 80 per cent of the reasonable charge, this amount could become the maximum of every charge under medicare, the AMA said. Or, were physicians to receive less than full payment and write off losses, the reduced payments could become the basis for the reasonable charge under medicaid.

The new regulation on utilization review would require a state medicaid plan to provide for utilization review of each item of service, including a physician's in his office or the patient's home. The AMA said it could lead to a set of national standards with authorized treatment for each medical condition limited in a manner set by regulation.

The AMA said it is not opposed to a "claims review" process to that now in operation in many areas or as conducted under medicare. Nor, the AMA added, did it find fault with inquiring into a physician's conduct where fraud is alleged, or where it appears on the basis of medicare claims submitted, that there is reasonable ground for further investigation of a possible fraud.

In another development, the Advisory Commission on Inter-governmental Relations supported a medicaid goal of comprehensive health care for the needy and medically needy by 1975, but proposed changes in financing and operation of the federal-state program.

The report was directed particularly to "the virtually unmanageable fiscal burden imposed on state and local governments by the program." It urged that consideration be given to "broadening medicaid's financial base through increased involvement of the private sector through an employer-employee contributory health insurance system." If Congress approved this proposal, it would be a giant step toward national compulsory government health insurance.

The commission rejected proposals to limit federal sharing in medicare and to establish national eligibility standards for beneficiaries.

The report was made public soon after the Senate voted a $500 million cutback in medicaid funds and when some states already were trimming their medicaid programs because of a financial pinch.

The commission recommended that the states "move vigorously to experiment with methods of increasing the efficiency and economy of health services under the medicaid program," including: (1) Reimbursing hospitals contingent on their operating under an acceptable standard of management efficiency, (2) expanding prior authorization for elective surgical procedures, (3) payment for physicians' services

(Continued on Page 475)


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in osteoarthritic pain

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The trial period is brief: 1 week. Try one tablet q.i.d. at first. Tandearil usually starts working within 3 to 4 days. When response occurs, as little as 1 or 2 tablets daily may hold back pain and stiffness, and increase joint motion.

On the next page is a summary of adverse reactions, contraindications, warning and precautions.

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It can help get his mind off his knee.

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For osteoarthritic knees, spines, shoulders, hips, etc.:

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Tandearil, oxyphenbutazone:
For brief summary see next page.

Geigy

TA-6006



Tandearil®
oxyphenbutazone

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently.

Warning: This drug is an analog of phenylbutazone; sensitive patients may be cross-reactive. If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Persistent or severe dyspepsia may indicate peptic ulcer; perform upper gastrointestinal x-ray diagnostic tests if drug is continued. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with caution in the first trimester of pregnancy, and in patients with thyroid disease.

Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patients should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia), sudden weight gain (water retention), skin reactions, black or tarry stools or other evidence of intestinal hemorrhage occur. Make complete blood counts at weekly intervals during early therapy and at 2-week intervals thereafter. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The more common are nausea and edema. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension, the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately after meals or with milk to minimize gastric upset. Drug rash occasionally occurs. If it does, promptly discontinue the drug. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), or a generalized allergic reaction similar to a serum sickness syndrome may occur and require permanent withdrawal of medication. Agranulocytosis can occur suddenly in spite of regular, repeated normal white counts. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity angiitis, pericarditis and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

Dosage in Osteoarthritis: Initial: 3 to 6 tablets daily in divided doses. Usually unnecessary to exceed 4 tablets daily. A trial period of one week is considered adequate to determine the therapeutic effect of the drug. Maintenance: Effective level often achieved with 1 or 2 tablets daily, should not exceed 4 tablets daily.

In selecting appropriate dosage in any specific case, consideration should be given to the patient's weight, general health, age and any other factors influencing drug response.

Availability: Tan, round, sugar-coated tablets of 100 mg. in bottles of 100 and 1000.

(B)R-46-800-A

For complete details, please see full Prescribing Information.

Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York 10502

(Continued from Page 471)

on a basis other than usual and customary charges, (4) use of co-payments for the purchase of specified health care services, and (5) improved techniques of utilization review.

The 26-member Commission is a bipartisan body established by federal law in 1959 to maintain continuing review of the relations among federal, state and local governments. Its membership consists of governors, mayors, county officials, state legislators, and representatives of both houses of Congress, the federal executive branch, and the general public. The chairman is Farris Bryant, former governor of Florida.

* * *

Congress approved a two-year extension of the regional medical programs and a one-year extension of the Hill-Burton program of federal aid for construction of hospitals and other health care facilities.

The legislation authorizes appropriation of $65 million in this fiscal year, ending next June 30, and $120 million for the next year for the regional medical programs. The Senate had voted a three-year extension but it was dropped in a House-Senate conference which worked out the compromise.

House conferees, however, emphasized that "this program, although a new established one, has already proved its value and should be considered as a permanent program." They said they accepted the two-year extension to give the next Congress an opportunity to review the program.

The Hill-Burton program was authorized $195 million for hospitals and $100 million for other health care facilities. The conferees abandoned Senate provisions for a new three-year program of federal loans of $200 million a year for hospital modernization and a guaranteed loan program of the same amount with a federal subsidy of interest. These provisions also were left for further consideration by the next Congress.

A total of $40 million was authorized for two years for construction and staffing of rehabilitation facilities for narcotics addicts and alcoholics. As a declaration of Congress, the measure states:

"Alcoholism is a major health and social problem afflicting a significant proportion of the public and much more needs to be done by public and private agencies to develop effective prevention and control."

The program of grants for family health service clinics for migratory agricultural workers was extended for two years with $9 million authorized for the current fiscal year and $15 million for the next year.

* * *

Congress approved legislation designating Nov. 17-23 as "National Family Health Week." The legislation termed the week "as a means of focusing national attention during the year upon the accomplishments of the American health care system and the central role played by the family physician in the maintenance of superior medical care for Americans of all ages and from all walks of life."

* * *

The Committee on Emergency Medical Services of the National Research Council has recommended establishment of a nationwide program for the training of ambulance personnel.

The committee proposed guidelines for such training, stating that there is at present "no uniformity in the course of instruction and . . . no generally accepted standards of proficiency to be used by those empowered to certify ambulance personnel."

The committee's recommended guidelines cover: either the standard or advanced first aid courses of the American National Red Cross as a prerequisite, the operation of emergency vehicles, safety precautions at the accident scene, priorities of care, records, the use of communication systems, the use of

(Continued on Page 478)

Getting her down presents no problem



.even though antihypertensive
aents like rauwolfia-thiazides
r longer work to your satisfac-
on. Something more potent is
eded. And there's one therapy
u should always consider for
ood pressure that's escaping
ntrol...something that in-
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Why? Because Esimil offers
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ochlorothiazide. Adding
drochlorothiazide makes guan-
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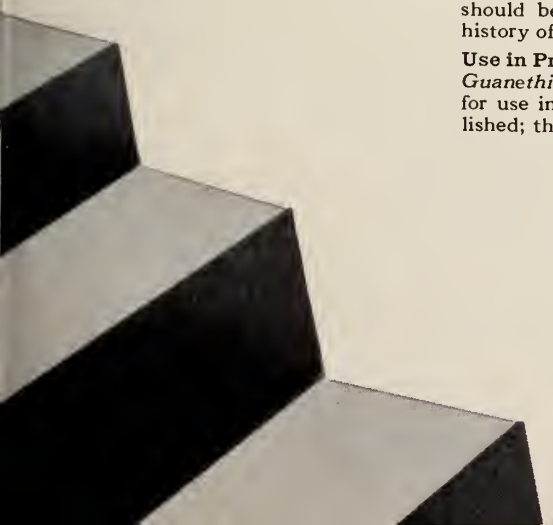
With Esimil you can usually
ver blood pressure to the level
u want. And it will probably
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e, Esimil could be just what
e patient needs.

he antihypertensive
tempered potency

Esimil®

nethidine monosulfate 10 mg
drochlorothiazide 25 mg



ESIMIL®

guanethidine monosulfate 10 mg
hydrochlorothiazide 25 mg

INDICATIONS

Hypertension which cannot be adequately controlled with simpler agents; moderate to severe hypertension; sustained hypertension; almost all forms of fixed and progressive hypertensive disease; when side effects of other antihypertensives prevent effective treatment.

CONTRAINDICATIONS

Guanethidine: Proven or suspected pheochromocytoma; hypersensitivity to guanethidine. Do not use with MAO inhibitors.
Hydrochlorothiazide: Anuria; progressive renal or hepatic disease; allergy to thiazides or other sulfonamide-derived drugs.

WARNINGS

Guanethidine: Orthostatic hypotension may occur early in treatment, on arising, during hot weather, and after alcohol, prolonged standing, or exercise. Caution patient to sit or lie down with the onset of weakness or dizziness.

Concurrent use with rauwolfia derivatives may cause bradycardia, mental depression, and postural hypotension.

Withdraw therapy 2 weeks prior to surgery if possible to reduce hazard of cardiac arrest or arrhythmia. If not, administer preanesthetic agents, anesthetics, and vasopressors cautiously in reduced dosage with oxygen and atropine ready for immediate use.

Febrile illness may reduce dosage requirements.

Due to catecholamine depletion and increased responsiveness to norepinephrine, special care is required when treating patients with a history of bronchial asthma.

Hydrochlorothiazide: Small bowel stenosis, with or without ulceration, has been associated with use of enteric-coated thiazides with potassium, and with enteric-coated potassium alone. Coated potassium should be used only when dietary supplementation is not practical and discontinued if gastrointestinal symptoms arise.

Titrate dosage carefully in patients with impaired renal or hepatic function or nitrogen retention; discontinue thiazides if progressive insufficiency is observed.

Thiazides may decrease glucose tolerance; use cautiously in diabetics. Hyperuricemia may occur but is readily reversed by uricosuric agents.

Thiazides may decrease arterial responsiveness to norepinephrine and increase responsiveness to tubocurarine. Hypotensive episodes under anesthesia have been observed; decrease dosage of preanesthetic and anesthetic agents.

The possibility of sensitivity reactions should be considered in patients with a history of allergy or bronchial asthma.

Use in Pregnancy

Guanethidine: The safety of guanethidine for use in pregnancy has not been established; therefore, this drug should be used in pregnant patients when, in the judgment of the physician, its use is deemed essential to the welfare of the patient.

Hydrochlorothiazide: Thiazides cross the placental barrier and appear in breast milk. Thus, adverse reactions seen in the adult may occur in the newborn.

PRECAUTIONS

Guanethidine: Give cautiously to patients with severe coronary insufficiency, recent myocardial infarction, or cerebrovascular insufficiency and with extreme caution in those with severe congestive failure. Peptic ulcers and some other chronic disorders may be aggravated by guanethidine.

Appetite suppressants (amphetamines) and mild stimulants (eg, ephedrine, methylphenidate) may decrease the hypotensive effect of guanethidine.

Wait one week after discontinuing MAO inhibitors before starting guanethidine.

Periodic blood counts and liver function tests are advised during prolonged therapy.

Hydrochlorothiazide: Monitor indicated blood chemistry and fluid and electrolyte balance carefully in patients on thiazide therapy, especially when patient is vomiting, receiving parenteral fluids, steroids, or digitalis. Supplemental potassium and nonrigid salt intake will help prevent hyponatremia, hypochloremic alkalosis, and hypokalemia.

ADVERSE REACTIONS

Guanethidine: Dizziness, weakness, lassitude, syncope, bradycardia, increase in bowel movements, diarrhea, inhibition of ejaculation, fluid retention, edema, congestive heart failure. Less frequently: dyspnea, fatigue, nausea, vomiting, nocturia, urinary incontinence, dermatitis, scalp hair loss, dry mouth, rise in BUN, ptosis of the lids, blurring of vision, parotid tenderness, myalgia, muscle tremor, mental depression, chest pains (angina), chest paresthesias, nasal congestion, weight gain, and asthma in susceptible individuals.

Hydrochlorothiazide: Anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic), pancreatitis, hyperglycemia, glycosuria, muscle spasm, weakness, restlessness, dizziness, vertigo, paresthesias, headache, xanthopsia, purpura, photosensitivity, rash, urticaria, necrotizing angiitis, leukopenia, thrombocytopenia, agranulocytosis, aplastic anemia. Orthostatic hypotension may occur and may be potentiated by alcohol, barbiturates, or narcotics. Whenever adverse reactions are moderate or severe, reduce dosage or withdraw therapy.

DOSAGE

Optimal dosage must be determined for each individual. *Note:* 10 mg guanethidine monosulfate present in Esimil is equivalent to 8.4 mg guanethidine sulfate USP (Ismelin®).

SUPPLIED

Tablets (white, scored), each containing 10 mg guanethidine monosulfate and 25 mg hydrochlorothiazide; bottles of 100.

Before starting therapy, consult complete product literature.

CIBA Pharmaceutical Company
Summit, New Jersey

2/3714-R1

CIBA

(Continued from Page 475)

equipment and supplies, medicolegal problems, and rescue procedures.

The levels of proficiency designed to result from the course proposed in the report are attainable in most areas of the country within a reasonable time, the committee said. However, to realize the greatest life-saving potential, the ambulance attendant of the future should be trained to the same level as lay assistants in emergency departments or medical corpsmen in combat areas; and, ideally he should be qualified to carry out, either independently or through voice communication with a physician, such procedures as tracheostomy, defibrillation, and mechanical external cardiac compression, the committee said.

To attain these goals, the committee said, accredited hospital training programs must be established that will produce professional ambulance attendants and emergency department assistants of the caliber of certified X-ray, laboratory, physical therapy, and other accredited medical technicians.

The ambulance attendant, it added, must be fully engaged in emergency care in an established career pattern that provides attractive compensation, prestige, and recognition deserving of his services as a member of the emergency care team. Where the needs for ambulance services are low so that he is not fully occupied, such as in small communities, he should be an employee of a hospital, where he can maintain his interest and proficiency as an assistant in the emergency department. intensive-care unit, or operating room, the committee said.

* * *

The President's Committee on Mental Retardation reported that three-fourths of the nation's six million mentally retarded live in urban ghettos and rural slums and were unwanted, unplanned children.

The committee's second annual report, entitled "The Edge of Change," dealt with the high incidence of retarded development among the poor, the shortage of manpower to serve the retarded, and the low quality of residential care available to most of them.

The committee's recommendations called for:

—Education and health services for every child from birth.

—An insurance system to give parents a free choice in selecting needed services.

—Development of national accreditation standards for residential facilities for the retarded.

—Voluntary family planning services for all Americans.

Retired Manpower Deputy Heads Medicare Program

The appointment of Theodore C. Bedwell, Jr., M. D., as Chief Medical Officer for the Medicare program is announced by Robert M. Ball, Commissioner of Social Security.

Dr. Bedwell was Director of Staff, Office of the Deputy Assistant Secretary of Defense (Manpower-Health and Medical) when he retired in August.

Upon his retirement, Dr. Bedwell was awarded the Distinguished Service Medal, the highest military award for noncombat duty.

He also served as Acting Deputy Assistant Secretary of Defense, as Assistant to the Surgeon General, USAF, and as Chief, Preventive Medicine Division, Office of the Surgeon General, USAF. In 1961, he organized the Aerospace Medical Division and served as its first commander.

The post to which Dr. Bedwell has been appointed is a new one, Ball noted. Erwin Witkin, M. D., Baltimore physician, who has taken time from the private practice of medicine to serve as Chief Medical Consultant on a part-time basis since 1966, will continue in that capacity.



Help clear up that miserable stuffed-up feeling with Dimetapp. Each hard-working Extentab brings welcome relief from the stuffiness, drip and congestion of upper respiratory conditions for up to 10-12 hours. Yet, patients seldom experience drowsiness or overstimulation. The key to success is the Dimetapp formula: Dimetane (brompheniramine maleate)—along with phenylephrine and phenylpropanolamine, two time-tested decongestants. They get the job done... in a hurry.

Indications: Dimetapp is indicated for symptomatic relief of the allergic manifestations of respiratory illnesses, such as the common cold and bronchial asthma, seasonal allergies, sinusitis, rhinitis, conjunctivitis, and otitis.
Contraindications: Hypersensitivity to antihistamines. Not recommended for use during pregnancy.
Precautions: Until patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension.
Side Effects: Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia, have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered.
Dosage: 1 Extentab morning and evening.
Supplied: Bottles of 100 and 500.

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in sinusitis, colds, U.R.I.

Dimetapp® Extentabs®

(Dimetane® [brompheniramine maleate], 12 mg.; phenylephrine HCl, 15 mg.; phenylpropanolamine HCl, 15 mg.)

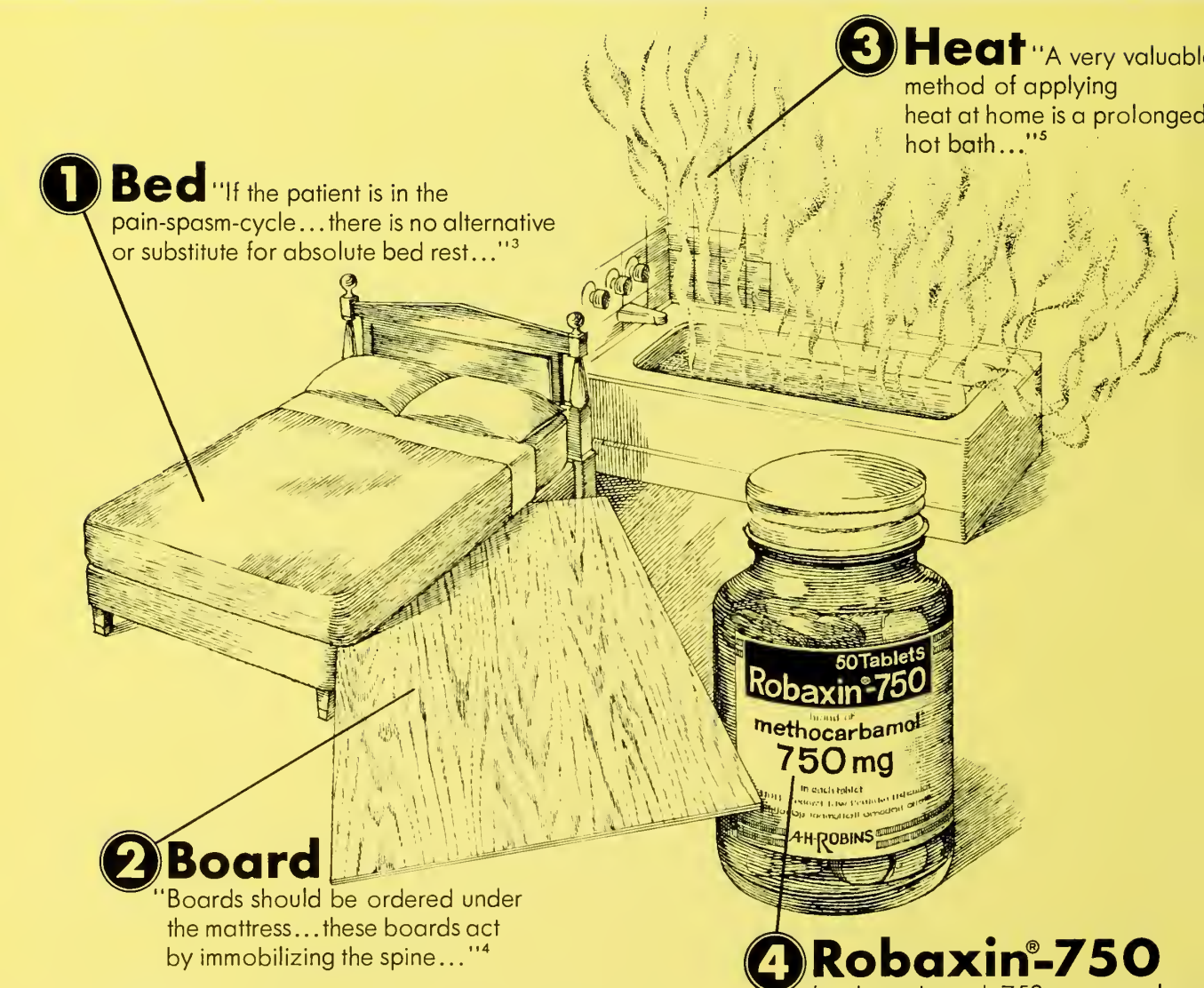
up to 10-12 hours clear breathing on one tablet



LOW-BACK PAIN

A CONSERVATIVE, FOUR-POINT PROGRAM

The low back pain that is most frequently seen in general practice is mechanical in nature, i.e., postural back pain, joint dysfunction and acute back strain.[1,2] For this type of discomfort, a conservative regimen is usually sufficient to relieve aches and pains, and to help keep the patient functioning. Components of this basic program include:



1 Bed "If the patient is in the pain-spasm-cycle... there is no alternative or substitute for absolute bed rest..."[3]

2 Board "Boards should be ordered under the mattress... these boards act by immobilizing the spine..."[4]

3 Heat "A very valuable method of applying heat at home is a prolonged hot bath..."[5]

4 Robaxin®-750 (methocarbamol, 750 mg. capsule-shaped tablets) A well-tolerated[6] skeletal muscle relaxant, methocarbamol helps relieve spasm "...without interfering with normal tone and movement."[7] And there is little likelihood of sedation.[6]

Indicated for relief of skeletal muscle spasm. **Contraindicated** in hypersensitive patients. **Side Effects** (lightheadedness, dizziness, drowsiness, nausea) may occur rarely, but usually disappear on reduced dosage. Hypersensitivity reactions develop infrequently. See product literature for further details. **Also available:** Robaxin® Tablets (methocarbamol, 500 mg.) Robaxin Injectable (methocarbamol, 1 Gm./10 cc.)

References: (1). Godfrey, C.M.: Applied Therap. 8:950, 1966. (2). Gattschalk, L.A.: GP 33:91, 1966. (3). Rawe, M.L.: J. Occup. Med. 2:219, 1960. (4). Cazen, L.: Sauth Dakata J. Med. 18:26, 1965. (5). Sata-Hall, R.: Med. Sc. 14:23, 1963. (6). Weiss, M. and Weiss, S.: J. Am. Osteapath. A. 62:142, 1962. (7). Feuer, S.G., *et al.*: New Yark J. Med. 62:1985, 1962.

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Expert On Burns Convinced Cancer's 'Catching'

Is cancer "catching?" Generally recognized today as a virus disease, are medical researchers about to moderate the dogmatic view that cancer is not communicable?

"The chief virus diseases," says the edition of *World Book Encyclopedia* published twenty years ago, "are smallpox, influenza, measles, mumps, poliomyelitis, yellow fever, rabies, psittacosis, dengue and the common cold." If cancer is a virus, can it be transmitted as readily as these others?

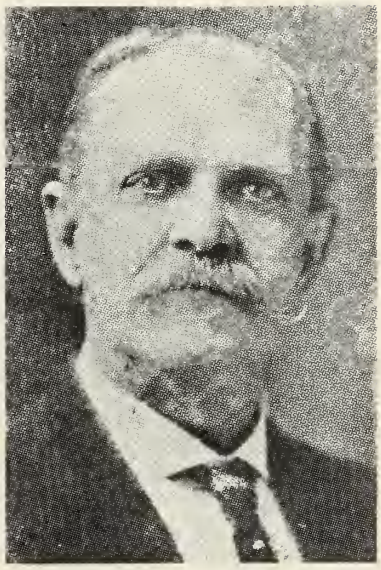
And, as a companion question, can the rapidly increasing incidence of cancer be explained entirely by improved diagnostic procedures?

In 1931 an 85-year-old doctor, internationally known for his unique treatment of burns, less widely but quite as positively known for his insistence that cancer was a communicable disease, died in Eufaula. Dr. William Preston Copeland was firmly convinced that there was such a thing as a "cancer house."

A two-volume, 1500-page work titled *Health Knowledge,* published 50 years ago, declares that "cancer houses" get their names "when person after person living in them gets the disease. It is very often noted that a husband and wife are both affected one after another." At another point the book adds: "It seems to be quite certain that the children (especially female) of parents who have died of cancer show slightly more than the average liability, though this fact is vastly exaggerated in the popular mind."

The edition of *World Book Encyclopedia* published in 1948 says:—"Scientists have tried for many years to discover some bacterium or virus that might cause cancer, but have discovered none. This means that cancer *apparently* is not contagious."

The Family Medical Encyclopedia, by Justus J. Schifferes, Ph. D., published nine years ago by Little, Brown, declares without qualification that "Cancer is neither contagious nor communicable. You cannot 'catch' cancer from cancer patients."



Dr. William P. Copeland

The Complete Medical Guide, by Benjamin F. Miller, M. D., revised and reissued last year, declares: "Fortunately, cancer is not contagious. No cancer has ever been transmitted from one patient to another. In the laboratory, scientists have succeeded in transmitting animal tumors and cancers. However, doctors, pathologists, nurses, and others who handle human cancer daily have never 'caught' the disease. It is therefore perfectly safe to visit, associate with, or care for anyone who is sick, or even dying, from cancer."

Dr. Copeland, for eight years president of the Barbour County Medical Society, according to Thomas M. Owens' *Dictionary of Alabama Biography,* is the grandfather of two Montgomerians, Mrs. J. Warren Andrews (whose father-in-law, by the way, was a life member of the Medical Association's Board of Censors) and Mrs. Lister Hill, wife of Alabama's senior senator.

Ten years ago Mrs. Hill published a family history under the title, *The Family Skeleton.* Of Dr. Copeland, her grandfather, she wrote:

"It was his theory that cancer is trans-

(Continued on Page 483)



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(Continued from Page 481)

mittable. After 50 years of research he concluded that there were houses in town that could be termed 'cancer houses' where one family after another contracted the disease while living there. These families were in no way related."

In another place, Mrs. Hill's book comments: "In the days when there were no miracle drugs, many doctors relied on morphine to ease the pain, and nature to do the rest. Dr. Copeland did not believe in ever giving morphine except under extenuating circumstances. He once stated that he had never lost a pneumonia patient. His method was to keep the patient in a warm room and to blister the lungs, front and back, with mustard plasters. Sometimes he used a pneumonia jacket, a shirt dipped into a solution of turpentine, gummed camphor (chipped up) and vasoline."

Twenty years after his death, when the Coconut Grove fire in Boston was still a tragic memory, the Saturday Evening Post devoted an article to him and his treatment of burns. It began:

"For burns, and for all burns in the event of a mass catastrophe when sufficient pressure dressing would presumably be unavailable, the experts are turning to the remarkable open-air exposure treatment. Efforts to develop such a treatment for burns go back at least to Hippocrates, father of medicine. The first major attempt in modern times was apparently one reported in 1887 in a letter written to the Medical Record. Dr. W. P. Copeland, Eufaula, Alabama, described two patients treated by a novel technique which he had devised largely from desperation.

"One of these was a young man badly burned on his face, ears and hands after a boiler explosion. Another doctor had previously prescribed what was then customary —daily dressing of oil, powder, soap and water—but the burns refused to heal.

"'The patient,' Dr. Copeland wrote, 'was rapidly acquiring the morphine habit by reason of the large doses given for the relief of pain, and the burns were doing badly.'

"Abandoning the dressings, he put the young man's hands in pasteboard boxes, not allowing anything to touch the burned surfaces. The ends of the boxes were covered with mosquito netting to keep off flies, and netting was erected about the face and ears. 'On the next day,' he related, 'the burned surface had become dry, and was covered with a thin film or scab, which gradually thickened. The case progressed satisfactorily and speedily to a cure with very little disfigurement.' He concluded, 'I do not know whether the plan has been previously recommended, but it has proved very effectual in my hands.'"

Heart Beats Steadily On— Without A Pericardium

One may survive with no trace of that membrane that normally surrounds and protects the heart, Dr. Lester B. Glover, associate Professor of Radiology, Medical College of Alabama, told the American Roentgen Ray Society meeting in New Orleans in October.

His subject was "Congenital Pericardial Defects" and his paper was the result of research conducted by a trio of Medical Center professors that also included Dr. Alberto Barcia, associate Professor of Radiology, and Dr. T. Joseph Reeves, Professor of Medicine, associate Professor of Physiology, and consultant in Medicine, Veterans Administration Hospital, Birmingham, as well as Professor of Cardiovascular Research, Research Center.

More than 2,500 attended the 69th birthday

meeting of the oldest medical specialty society in Radiology in the United States.

Although total absence of the pericardium can cause discomfort and inconvenience, it need not be fatal, Dr. Glover told ARRS members, and cited the example of a 20-year-old man referred to the medical center for heart study. The patient had been told at 15 that he had an enlarged heart. At that time he had suffered chest pains brought on by anxiety or worry, and occasionally by exercise.

Chest X-rays and chest fluoroscopy at the Medical Center suggested the absence of the pericardium. Exploratory chest surgery confirmed the diagnosis. Surgery also confirmed that there were no adhesions that might cause pressure changes to the coronary arteries. No correction was attempted by the surgeon.

Reporting on a study of the 87 clinical cases of totally or partially missing pericardium described during the past 30 years, Dr. Glover explained methods of diagnosing defects of the pericardium.

X-ray studies of patients with pericardial openings, or missing sections, usually show that the heart is moved to the left of its normal position, and that it is rotated clockwise. X-ray procedures also reveal abnormal mobility of the heart when the heart covering is missing.

Absence of the left side of the pericardium accounts for most of the cases, Dr. Glover said. Partial or total absence of the right side is rare, and total absence of the pericardium is even more unusual.

Defects of this nature are probably much more common than the number reported would indicate, Dr. Glover pointed out. Although there have been 87 cases reported in medical literature during the past 30 years, 57 of these were diagnosed during the past eight years.

ACHROMYCIN® V
TETRACYCLINE

Contraindications: Hypersensitivity to tetracycline.

Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.

Precautions: Nonsusceptible organisms may overgrow; treat superinfection appropriately. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Side Effects: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity reactions*—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

Upon adverse reaction, stop medication and treat appropriately.

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359-8

Suspected tetracycline-sensitive infection?

While waiting for the results of the sensitivity test, start the therapy likely to succeed...

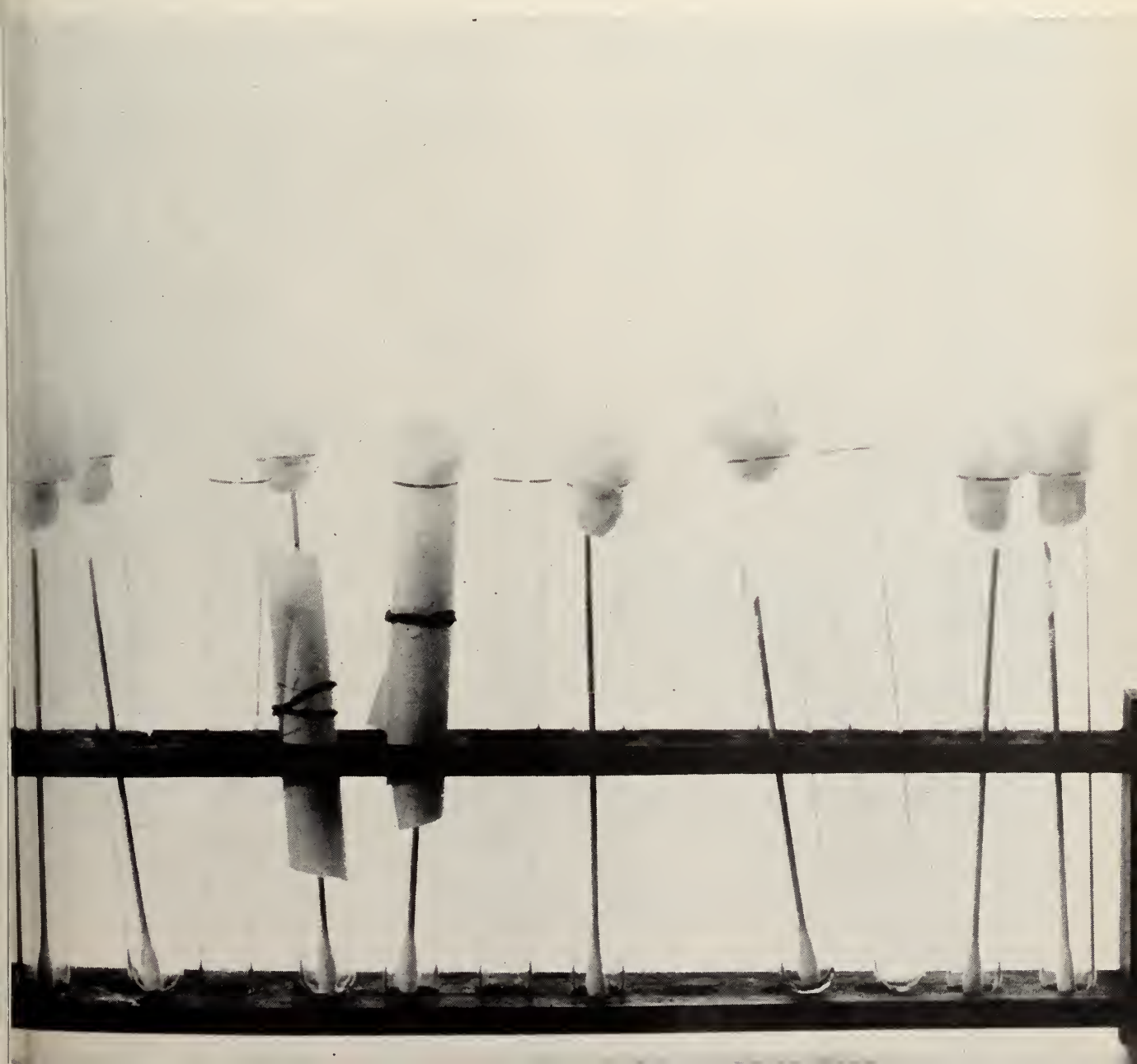
Although of course it can't replace routine sensitivity testing, your prescription for ACHROMYCIN® V, in a way, provides the ultimate test of therapy under rigorous *in vivo* conditions.

Because ACHROMYCIN® V is effective in treating so many common infections—caused by strains of tetracycline-sensitive organisms—doesn't *stat* dosage of this time-tested antibiotic make good sense?

←Prescribing Information

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TETRACYCLINE
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The price differential is inconsequential.





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Vital Statistics

NEW MEMBERS

Baldwin County

Russell, Robert Burke, b 41, mc L. S. U. 67, recip La. 68, Spanish Fort Shopping Center, Spanish Fort, Ala. 36527. GP—433-1678.

Coffee County

Grimes, James Thomas, b 19, mc Cornell 43, recip Mich. 46, 1506 West College Avenue, Enterprise, Ala. 36330. I-C—347-2369. (Transfer from nonmember)

Colbert County

Lambert, James Spullock, b 26, mc Ga. 55, recip Ga. 67, West Colbert Clinic, Cherokee, Ala. 35616. GP—359-4223.

Wayland, James Lee, b 33, mc Ala. 63, sb 64, Shaols Hospital, Sheffield, Ala. 35660. R—383-7441.

DeKalb County

Taylor, Emmett Lee, Jr., b 38, mc Ala. 67, sb 68, P. O. Box 5, Fyffe, Ala. 35971. GP—623-2106.

Etowah County

McIntyre, Michael Winfield, b 37, mc Univ. of N. Y. 62, recip NBME 65, 410 South 3rd Street, Gadsden, Ala. 35901. Oph—547-3112.

Madison County

Hale, Robert Baker, Jr., b 36, mc Vanderbilt 63, recip Tenn. 68, 401 Sivley Road, Huntsville, Ala. 35801. Pd—539-4731.

Moore, Billy Sam, b 36, mc Vanderbilt 63, NBME 68, 401 Sivley Road, Huntsville, Ala. 35801. Path—881-6151.

Wheeler, Don Allan, b 37, mc Univ. Tenn. 61, recip Tenn 68, 930 Franklin Street, Suite 207, Huntsville, Ala. 35801. ObG—534-8473.

Talladega County

Clark, Glenn Luther, b 35, mc Ala. 63, recip NBME 66, Sylacauga, Ala. 35150. ALR—245-5241.

DeRuiter, James William, b 36, mc Univ. Miss. 60, recip Miss. 68, Talladega, Ala. 35160. ObG—362-4683.

MEMBERS REMOVED

Bibb County

Pratt, Alsey Clements, Jr., Centreville, Ala. 35042—deceased July 22, 1968.

NONMEMBERS REMOVED

Montgomery County

Hendrix, Richard Walker, Jr., 474 South Court, Montgomery, Ala. 36104—deceased.

CHANGE OF ADDRESS OF MEMBERS

Baldwin County

Dietze, Ferdinand H., present Fairhope, Ala. 36532, to P. O. Drawer AD, Fairhope, Ala. 36532.

Godard, Claud G., present Fairhope, Ala. 36532, to P. O. Box AB, Fairhope, Ala. 36532.

Johnson, Robert H., present Fairhope, Ala. 36532, to P. O. Drawer AC, Fairhope, Ala. 36532.

Jordan, Henry C., present Fairhope, Ala. 36532, to P. O. Drawer L., Fairhope, Ala. 36532.

Mullins, Henry C., Jr., present Fairhope, Ala. 36532, to 317 Magnolia Ave., Fairhope, Ala. 36532.

Yancey, Thomas H., present Fairhope, Ala. 36532, to 317 Magnolia Ave., Fairhope, Ala. 36532.

Bibb County

Crenshaw, James H., present Centreville, Ala. 35042, to 1634 Main Street, Humboldt, Tenn. 38343.

Calhoun County

McGinnis, Gaston O., present Anniston, Ala. 36201, to 216 East 10th Street, Anniston, Ala. 36201.

Colbert County

Mitchell, James A., present Sheffield, Ala. 35660, to P. O. Box 230, Tuscumbia, Ala. 35674.

Etowah County

Ennis, Arthur L., present Gadsden, Ala. 35901, to 303 Bay Street, Gadsden, Ala. 35901.

Simpson, William H., present Gadsden, Ala. 35901, to 303 Bay Street, Gadsden, Ala. 35901.

Vance, Scott, present Gadsden, Ala. 35901, to 415 South 1st Street, Gadsden, Ala. 35901.

Webb, Virginia E., present Gadsden, Ala. 35901, to Calvert, Ala. 36513.

Jefferson County

Cain, Walter S., present Birmingham, Ala. 35205, to 1807-11th Avenue South, Birmingham, Ala. 35205.

Compton, Merrill E., Jr., present Bessemer, Ala. 35020, to 420 Woodward Building, Birmingham, Ala. 35203.

Karl, Edward A., present Birmingham, Ala. 35234, to 920 South 19th Street, Birmingham, Ala. 35205.

Moore, Elbert L., present Birmingham, Ala.

(Continued on Next Page)



One by one
the family's downed
Because the
G.I. bug's around

Parepectolin for quick relief of acute diarrhea
...soothes colicky pain with paregoric*
...consolidates fluid stools with pectin
...adsorbs irritants with kaolin,
and protects intestinal mucosa

Whether it's a 24-hour "bug", a food problem, or simply nervousness and anxiety, Parepectolin will bring the diarrhea under control until etiology can be determined. In some cases, Parepectolin may be all the therapy necessary.

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Each fluid ounce of creamy white suspension contains:
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Contains opium (¼ grain) 15 mg. per fluid ounce.
warning: may be habit forming
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Rowe, Luther C., present Birmingham, Ala. 35233, to 2022-15th Avenue South, Birmingham, Ala. 35205.

Sullivan, Percy G., present Birmingham, Ala. 35206, to 551 Huffman Road, Birmingham, Ala. 35215.

Upchurch, James C., present Fairfield, Ala. 35064, to No. 12, Midfield Park Place, Birmingham, Ala. 35228.

Watson, Horace E., present Birmingham, Ala. 35203, to 420 Woodward Bldg., Birmingham, Ala. 35203.

Whitman, Marcus, Jr., present Birmingham, Ala. 35233, to 1425 South 21st Street, Birmingham, Ala. 35205.

Madison County

Striplin, William H., Jr., present Huntsville, Ala. 35801, to 800 Madison Street, Huntsville, Ala. 35801.

Marion County

Gaba, William F., present, Birmingham, Ala. 35205, to 2225 Myrtlewood Dr., Birmingham, Ala. 35216.

Mobile County

Cobb, Jeptha B., present Dothan, Ala. 36301, to 21 Turnout Lane, Mobile, Ala. 36608.

Cranton, John R., present Birmingham, Ala. 35233, to 158 Louiselle St., Mobile, Ala. 36607.

Montgomery County

Hubbard, Thomas B., present Montgomery, Ala. 36104, to 3235 Mastin Lane, Montgomery, Ala. 36106.

Penton, Robert S. B., present Wetumpka, Ala. 36092, to P. O. Box 7, Rockford, Ala. 35436.

Stern, Louis H., present Montgomery, Ala. 36111, to Pathology Department, West Jefferson General Hospital, Marrero, La. 70072.

Talladega County

Denny, Robert C., Jr., present Talladega, Ala. 35160, to 1819 Crestwood Boulevard, Irondale, Ala. 35210.

Fitts, Floyd O., Jr., present Tuscaloosa, Ala. 35401, to 918-5th Avenue East, Tuscaloosa, Ala. 35401.

TRANSFER MEMBERS

Cullman County

Pinkerton, Haskell Andrew, 116 East 2nd Street, Cullman, Ala. 35055. (Transfer from member of Jefferson County to member Cullman County Medical Society.)

Etowah County

Reagan, Jack Earl, 409 Noojin Building, Gadsden, Ala. 35901. (Transfer from member of Lauderdale County to member Etowah County Medical Society.)

NEW MEMBERS

Clarke County Board of Censors

W. H. Rudder, Chairman

P. H. Warren

C. E. May

J. P. Mudd, Jr.

R. W. Larrimore

NEW TELEPHONE NUMBERS

Davis, David W., Jr.—937-4612

Upchurch, James C.—786-1766

Calendar of Annual Meetings

Medical Association of the State of Alabama

1969, April 24-26, Carriage Inn, Huntsville

1970, April 30-May 2, Mobile

1971, April 22-24, Birmingham

1972, April 20-22, Montgomery

1973, April 18-21, Mobile

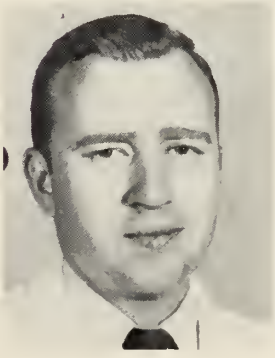
New Physicians Licensed to Practice in Alabama



Dalton Anthony Bedsole, M. D., Medical College of Alabama, 1967, Reciprocity with National Board of Medical Examiners—Intends to locate in Birmingham.



Stanley Jackson Self, M. D., Medical College of Georgia, 1966, Reciprocity with Georgia—Intends to locate in Birmingham (Residency).



Gerald Tyrone Cochran, M. D., Medical College of Alabama, 1967, Reciprocity with National Board of Medical Examiners—Intends to locate in Piedmont.



McLeod Patterson, M. D., Tulane University School of Medicine, 1939, Reciprocity with Louisiana—Intends to locate in Columbus, Georgia.



William Ferrel Harper, M. D., Medical College of Georgia, 1965, Reciprocity with Georgia—Intends to locate in Mobile (Residency).



William Reginald Shamblin, M. D., Tulane University School of Medicine, 1962, Reciprocity with Louisiana—Intends to locate in Tuscaloosa.



Thomas Edward Murphy, M. D., Georgetown University School of Medicine, 1962, Reciprocity with National Board of Medical Examiners—Intends to locate in Montgomery (Gunter AFB).



Thomas Emerson Simpkins, Jr., M. D., University of Tennessee College of Medicine, 1960, Reciprocity with Mississippi—Intends to locate in Birmingham.



Paul Shan Williamson, M. D., University of Oklahoma School of Medicine, 1946, Reciprocity with Oklahoma—Intends to locate in Andalusia.



John William Foft, M. D., University of Nebraska, 1954, Reciprocity with Nebraska—Intends to locate in Birmingham.



Bruce Wayne Russell, M. D., Medical College of Alabama, 1967, Reciprocity with National Board of Medical Examiners—Intends to locate in Walker County.

Kenneth William Smith, M. D., Medical College of South Carolina, 1965, Reciprocity with South Carolina—Intends to locate in Birmingham (Residency).

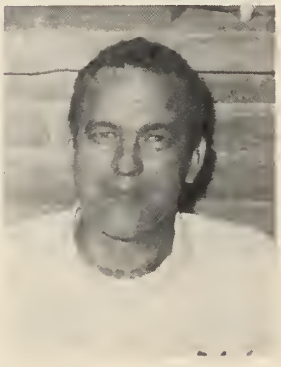




Charles Charner Heard, M. D., Medical College of Georgia, 1964, Reciprocity with Georgia—Intends to locate in Geneva.



John Aldridge Harris, M. D., Medical College of Alabama, 1966, Reciprocity with National Board of Medical Examiners—Intends to locate in Birmingham.



John Little Watwood, M. D., Medical College of Alabama, 1964. Reciprocity with National Board of Medical Examiners—Intends to locate in Childersburg.

David Alexander Coats, M. D., Bowman Gray School of Medicine, 1964, Reciprocity with North Carolina—Intends to locate at Fort Rucker.

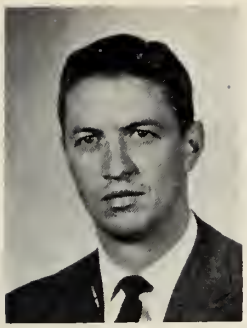




John Richard Bruhn, M. D., George Washington University School of Medicine, 1960, Reciprocity with National Board of Medical Examiners—Intends to locate in Birmingham.



Percy Cleothus Moss, Jr., M. D., Meharry Medical College, 1967, Reciprocity with Georgia—Intends to locate in Montgomery.



Erven Jean Nelson, M. D., George Washington University School of Medicine, 1958, Reciprocity with National Board of Medical Examiners—Intends to locate in Birmingham.



Frank Bernard Olsen, M. D., University of Colorado School of Medicine, 1936, Reciprocity with Colorado—Intends to locate in Jasper.



Norbert Earl Perret, Jr., M. D., Louisiana State University School of Medicine, 1962, Reciprocity with Louisiana—Intends to locate in Demopolis.



Gary Eugene Phillips, M. D., Medical College of Alabama, 1966, Reciprocity with National Board of Medical Examiners—Intends to locate in Birmingham.



Harold Warren Schnaper, M. D., Duke University School of Medicine, 1949, Reciprocity with National Board of Medical Examiners—Intends to locate in Birmingham.

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Mario Victor Scandiffio, M. D., George Washington University School of Medicine, 1928, Reciprocity with New York—Intends to locate in Birmingham.



Harold Scott Strasser, M. D., University of Florida College of Medicine, 1962, Reciprocity with National Board of Medical Examiners—Intends to locate in Montgomery (Maxwell AFB).



Robert Andrew Reed, M. D., Emory University School of Medicine, 1962, Reciprocity with Georgia—Intends to locate in Mobile.



Donald Lee Vine, M. D., Stanford University School of Medicine, 1966, Reciprocity with National Board of Medical Examiners—Intends to locate in Birmingham.



Thomas Fleming Taylor, M. D., University of Wisconsin Medical School, 1967, Reciprocity with Wisconsin—Intends to locate in Montgomery (Maxwell AFB).



Barry Lewis Wilson, M. D., Medical College of Alabama, 1967, Reciprocity with National Board of Medical Examiners—Intends to locate in Mobile.



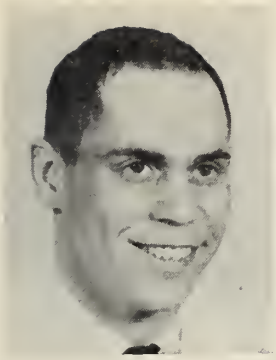
Harold Simon Perlmutter, M. D., Chicago Medical School, 1964, Reciprocity with National Board of Medical Examiners—Intends to locate in Montgomery (Maxwell AFB).



Thomas David Woodman, M. D., Medical College of Alabama, 1967, Reciprocity with National Board of Medical Examiners—Intends to locate in Birmingham.



Robert Howard Story, M. D., Medical College of Alabama, 1967, Reciprocity with National Board of Medical Examiners—Intends to locate in Tuskegee.



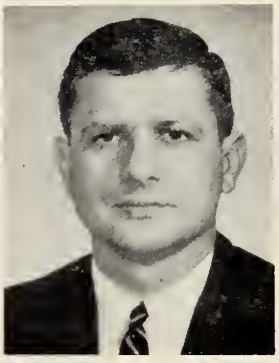
Myron Howard Hawkins, Jr., M. D., Medical College of Alabama, 1967, Reciprocity with National Board of Medical Examiners—Intends to locate in Gadsden, Alabama.



Allen Lloyd Spitler, M. D., University of Missouri School of Medicine, 1966. Reciprocity with Missouri—Intends to locate at Fort McClellan.



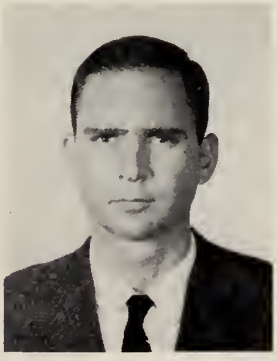
Stewart Godbey Carrington, M. D., Louisiana State University School of Medicine, 1957, Reciprocity with Louisiana—Intends to locate in Mobile.



Hugh Mallory Reeves, M. D., Tulane University School of Medicine, 1962, Reciprocity with Louisiana—Intends to locate in Selma.



Samuel Harvey Chastain, M. D., Medical College of Alabama, 1967, Reciprocity with the National Board of Medical Examiners—Intends to locate in Birmingham.



George Madison Cravey, Jr., M. D., University of Florida College of Medicine, 1967, Reciprocity with Georgia—Intends to locate in Birmingham.

Page 1

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(Act of October 23, 1962; Section 4369, Title 39, United States Code)

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MANAGING EDITOR (Name and address): L. P. Patterson, 19 South Jackson Street, Montgomery, Alabama 36104

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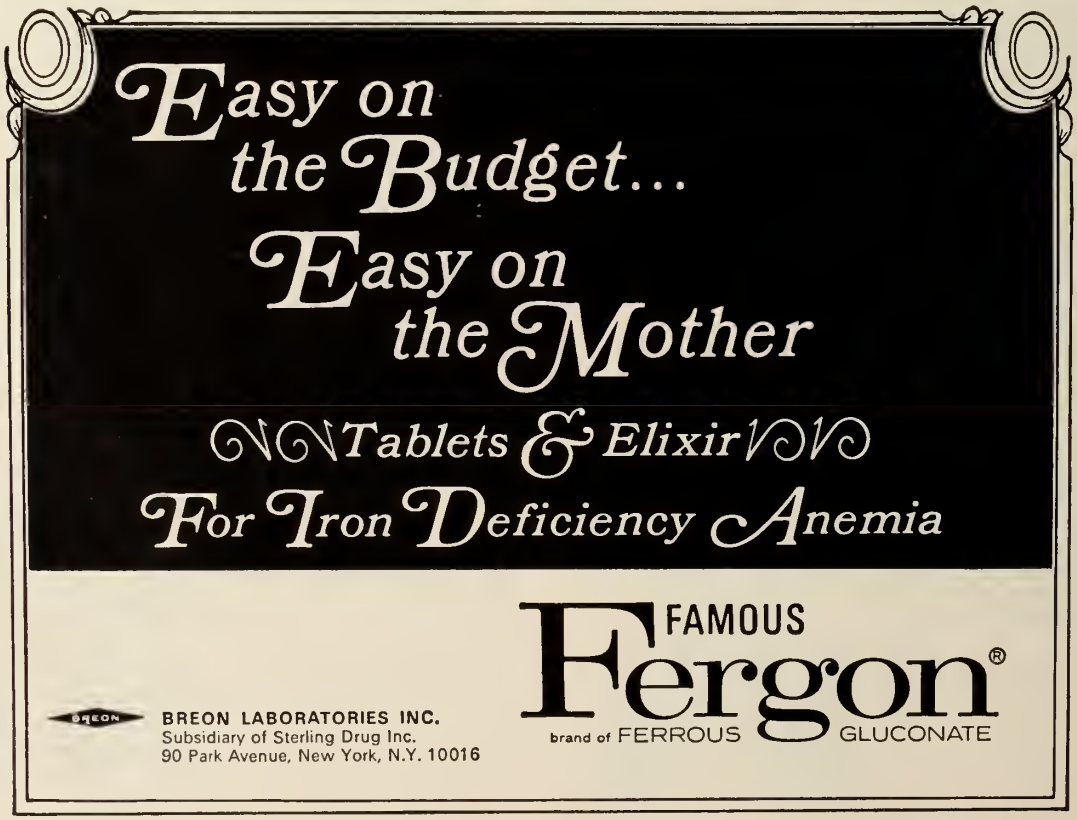
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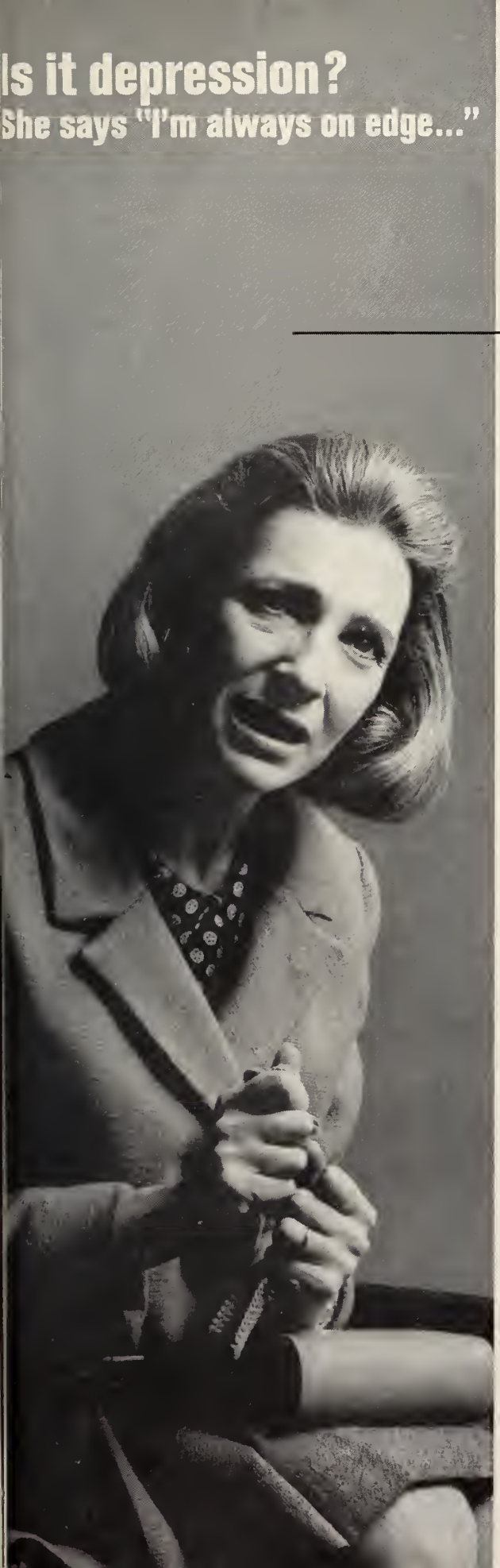
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Is it depression?

She says "I'm always on edge..."



...but her other symptoms:

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an underlying depression.

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Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving).Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral*—Adults: Mild and moderate anxiety and tension, 5 or 10 t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. Geriatric patients: 5 mg b.i.d. to q.i.d. (See Precautions.)

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1968 Report on Tuberculosis Control Program 542



Francis A.
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DECEMBER 1968



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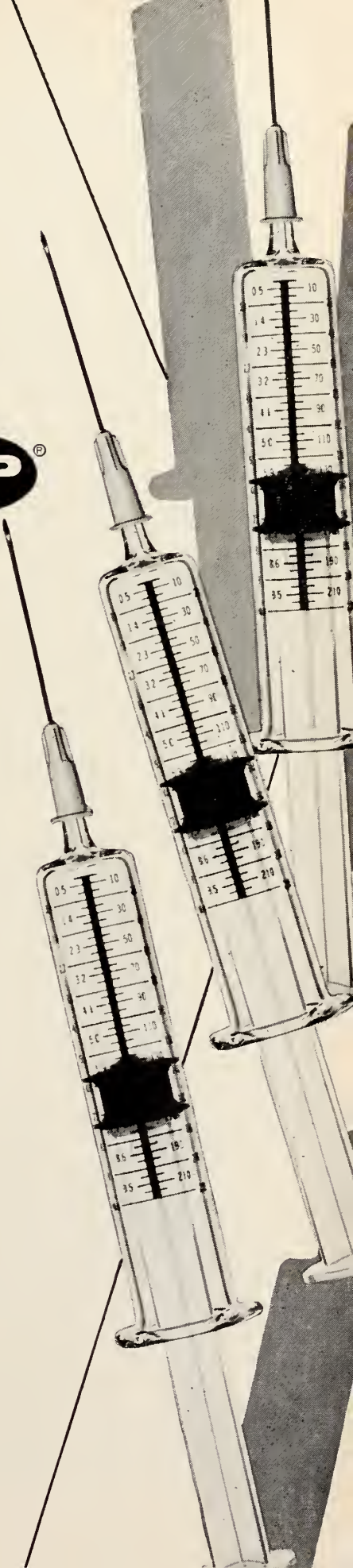
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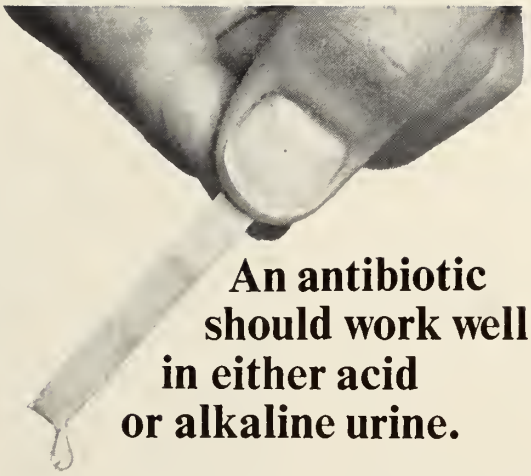
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Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system – anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin – maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney – rise in BUN, apparently dose-related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions–urticaria, angioneurotic edema, anaphylaxis. Teeth – dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

Capsules: 150 mg; Tablets: film coated – 300 mg, 150 mg and 75 mg of demethylchlortetracycline HCl.

355-8

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President's Page



E. L. McCafferty, Jr.

Each of us is aware of the liability that we accept in treating any patient and, of necessity, protect ourselves with so-called malpractice insurance. This is rapidly becoming a more serious problem each year.

On Nov. 6, 1968, your liability group insurance premiums were increased by 50 per cent. This rate increase has already been approved by the Alabama Department of Insurance and is parallel with the countrywide experiences of insurance companies on a national level.

We realize that costs for all goods and services have been increasing during the past few years. This is equally true in the number of insurance claims and the dollar amount received in processing those claims. However, an increase of 50 per cent at a single stroke would appear alarming and, as a state organization, it would seem that this is an additional area in which we can be of service to the members of the profession. Our concern would be not so much as regards the simple dollar increase in premiums but in reviewing some of the causes that prompt malpractice suits.

At the Board of Trustees meeting on Nov. 3, 1968, a full discussion of malpractice claims and insurance was undertaken and programs considered which would relieve the continuing increasing threat of legal actions. By meeting with the insurance carrier in a spirit of mutual responsibility, attention was drawn to means of great cooperation between the carrier, the medical profession and the Bar Association.

Many insurance companies have already restricted their writing of this class of business. If the risk experiences of the physicians in California should spread to Alabama in the near future, we would not only have a problem in obtaining insurance, but also the premiums paid for this protection will materially increase the cost of practicing medicine. By the same token the insurance companies need a large number of policy holders to make any actuary method economically sound and in this sense they are dependent on the medical profession to buy their policies.

The Insurance Committee of the Medical Association of the State of Alabama is both knowledgeable and conscientious. All of us have benefited by the efforts the committee has exerted in our behalf, and the group programs they have recommended to the general membership. They will of course be primarily responsible of guiding our state association in this program and it is my feeling that, in the long run, constructive steps will be taken to reach an agreeable conclusion for all parties concerned.

At the present time certain steps have been taken that I hope will prove to be in the best interest of the medical profession.

1. The malpractice laws that have been introduced in the California Legislature are

being reviewed and those that appear applicable to Alabama will be studied, and if endorsed by the Legislative Committee, introduced at the next session of the Alabama Legislature in May, 1969.

2. Communications are being established with the Alabama Bar Association in an effort to determine the feasibility of a joint Medico-Legal Committee to settle justifiable claims prior to the formality of legal procedure.

3. An education program to familiarize the profession of common pitfalls that we doctors make and that subsequently lead to malpractice suits.

4. A mutual type insurance plan whereby refunds would be made at the end of the year based on actual company experience in this state or, conversely, rates would be raised to cover years in which unusual loss experiences occurred.

5. Probably the most important recommendation that we can undertake, no matter who the carrier, is urging the full support of the medical profession in joining the group plans and thereby reducing the premiums for the individual physician.

It is my hope that these conferences will be fruitful, that progress will be made in retaining our rates at a reasonable level and, more important, that we can eliminate many of the nuisance malpractice suits that plague us.

Since there is no simple solution to this problem, and since each of you will be affected in one way or another by our efforts, it is requested that those of you who have suggestions or recommendations, send them to me without delay. Be assured that your views will be given every consideration.

E. L. McCafferty, Jr.

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The Woman's Auxiliary

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AUXILIARY PLEDGE

"I pledge my loyalty and devotion to the Woman's Auxiliary to the American Medical Association. I will support its activities, protect its reputation and ever sustain its high ideals."

Since my last President's Page was written, my time has been well occupied with conferences, workshops, and mailing many letters and the State Yearbooks.

I attended the 25th Annual Conference September 29-October 2 in Chicago, and found it to be both stimulating and helpful. Home-centered health care, use and abuse of alcohol and drugs by today's youth, AMA-ERF, speakers' seminars, medical manpower, legislation, Project HOPE, and health careers were among the subjects discussed. One hundred seventy-five Auxiliary leaders attended this conference. Mrs. C. C. Long, National President, and Mrs. John Chenault, President-Elect, presided at the sessions, which were well planned and organized.

"Accent on Youth" is the theme for this year, and Mrs. Long wishes us to emphasize Children and Youth in the State Auxiliaries. "Accent on You" was the theme of the conference. "The Physician's Family" was discussed by Joseph B. Trainer, M. D., Associate Professor of Physiology and Medicine, University of Oregon Medical School. He described the doctor and his characteristics, and gave suggestions for the wife of the doctor to bring out the best in him, even though her role makes great demands upon her.

"Each partner must," he stated, "meet the need of the other for attention, approval, love and affection."

Herbert A. Raskin, M. D., clinical Associate Professor, Department of Psychiatry, Wayne State University, discussed "The Use and Abuse of Alcohol and Drugs by Today's Youth." He emphasized that there is no such thing as a safe drug, and explained about the proper use and abuse of drugs.



Mrs. Robert K. Wilson, Sr.

Dwight L. Wilbur, M. D., president, American Medical Association, was the guest speaker at one of the luncheons. His subject was "Medical Manpower—Where do you go from Here?" He reminded the Auxiliary of its influential position in guiding youth into health careers, and emphasized that programs in health careers must "escalate vertically."

William B. Walsh, M. D., president and medical director, Project HOPE, stated that the ship HOPE is probably the best ambassador of good will this country has ever had.

At a dinner sponsored by AMPAC, the guest speaker was Shirley Temple Black, who stressed that our country needs strong,

(Continued on Page 505)

In the complex picture of moderate to severe anxiety...



there is a new reason for prescribing Mellaril (Thioridazine HCl)

effectiveness in mixed anxiety-depression

Long recognized for its usefulness in the treatment of moderate to severe anxiety, Mellaril is now also known to be effective against mixed anxiety-depression.

Often the symptoms of anxiety states are difficult to sort out—even with the most careful probing. The patient may manifest symptoms of agitation, restlessness, insomnia, somatic complaints. But what of the depression that may be mixed in the total picture? It is reassuring to know that Mellaril may be prescribed—with strong possibilities of success—when there is anxiety alone or a mixture of anxiety and depression.

Before prescribing or administering, see Sandoz literature for full product information, including adverse reactions reported with phenothiazines. The following is a brief precautionary statement.

Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.

Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when necessary.

Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving). Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascular System*—Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers, including Mellaril (thioridazine hydrochloride). While there is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients previously showing electrocardiographic changes. The use of periodic electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. *Other*—A single case described as parotid swelling.

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(Thioridazine HCl)
25 mg. t.i.d.

for moderate to severe anxiety and mixed anxiety-depression

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● Dioctyl Sodium Sulfosuccinate (to counteract constipating effect of iron)	100 mg
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Vitamin B_2	7.5 mg
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Vitamin B_{12}	50 mcgm
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Niacinamide	30 mg
Folic Acid	0.05 mg
Pantothenic Acid	15 mg

Bottles of 60

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anticostive, *adj.* (*anti* opposed to + *costive* causing constipation.) Against constipation. Now isn't that a good idea in an iron-containing hematinic?

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TAO®(triacetyloleandomycin)

Brief Summary

INDICATIONS: Include staphylococci, streptococci, pneumococci and gonococci. Recommended for acute, severe infections where adequate sensitivity testing has demonstrated susceptibility to this antibiotic and resistance to less toxic agents.

CONTRAINDICATIONS: Contraindicated in pre-existing liver disease or dysfunction, and in individuals hypersensitive to the drug.

PRECAUTIONS: CAUTION: USE OF THIS DRUG MAY PRODUCE ALTERATIONS IN LIVER FUNCTION TESTS AND JAUNDICE. CLINICAL EXPERIENCE AVAILABLE THUS FAR INDICATES THAT THESE LIVER CHANGES WERE REVERSIBLE FOLLOWING DISCONTINUATION OF THE DRUG.

Not recommended for prophylaxis or in the treatment of infectious processes, which may require more than ten days continuous therapy. In view of the possible hepatotoxicity of this drug when therapy beyond ten days proves necessary, other less toxic agents should be used. If clinical judgment dictates continuation of therapy for longer periods, serial monitoring of liver profile is recommended, and the drug should be discontinued at the first evidence of any form of liver abnormality. When treating gonorrhea in which lesions of primary or secondary syphilis are suspected, proper diagnostic procedures, including dark-field examinations, should be followed. In other cases in which concomitant syphilis is suspected, monthly serological tests should be made for at least four months. When used in streptococcal infections, therapy should be continued for ten days to prevent the development of rheumatic fever or glomerulonephritis. The use of antibiotics may occasionally permit overgrowth of nonsusceptible organisms. A resistant infection or superinfection requires re-evaluation of the patient's therapy. In the event such occurs with this drug the medication should be discontinued, and specific antibacterial and supportive therapy instituted.

ADVERSE REACTIONS: Although reactions of an allergic nature are infrequent and seldom severe, those of the anaphylactoid type have occurred on rare occasions.

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In vitro
susceptibility results
with TAO® (triacetyl-
oleandomycin)
in *Staphylococcus aureus* cultures,
as shown in
studies of
antibiotics.

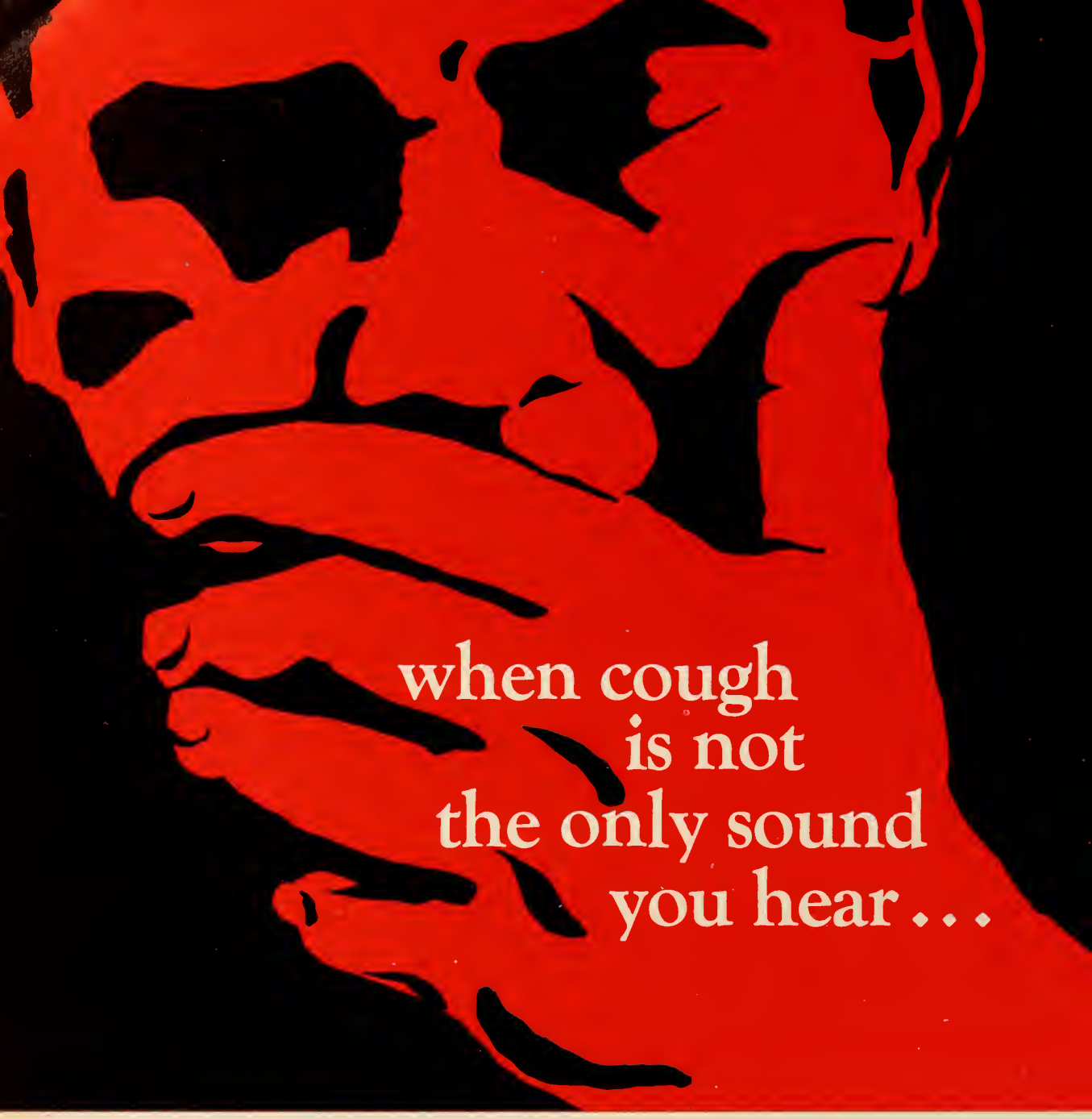
SUSCEPTIBILITY RESULTS[1,2,3]
Staphylococcus aureus

# OF CULTURES	YEAR	% EFFECTIVE
6,723	1962	88.6%
5,435	1963	88.0%
10,384	1964	88.5%

References: 1 Fowler, J. Ralph et al Clinical Medicine 70 547 (Mar.) 1963 2 Isenberg, Henry D Health Laboratory Science 1 185 256 (July Aug 1964 3 Isenberg, Henry D Health Laboratory Science 2 163 173 (July 1965

TAO® (triacetyl-
oleandomycin)
is a macrolide antibiotic, for use only in
the treatment of acute severe
infections where adequate
sensitivity testing has
demonstrated susceptibility
to this antibiotic and resistance
to other less toxic agents.





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. . . **because** OMNI-TUSS is indicated for cough associated with upper respiratory tract infections, bronchitis, bronchiectasis, bronchial asthma, emphysema, sinusitis and rhinitis, hay fever, or other allergic conditions. Any of these conditions may exhibit the general symptom syndrome—coughing, wheezing, bronchospasm, and tenacious mucus—which may benefit from the antitussive, bronchodilative, antihistaminic, and expectorant action of Omni-Tuss.

The therapeutic usefulness of Omni-Tuss is enhanced by a unique resin complex formulation providing the clinically desirable advantages of: (1) uniform drug availability throughout an extended period, (2) 8 to 12 hours of symptomatic control, (3) minimal dosage requirement, (4) minimal side effects.

Economical, efficient **b.i.d.** dosage—extremely well-tolerated by children, 6-12, and adults.

'Omni Tuss' Suspension: Each teaspoonful (5 cc.) contains 10 mg. codeine (Warning: May be habit-forming), 5 mg. phenyltoloxamine, 3 mg. chlorpheniramine, 25 mg. ephedrine, all as cation exchange resin complexes of sulfonated polystyrene, and 20 mg. guaiacol carbonate.

Available on prescription only. Class X exempt narcotic. Permissible on oral prescription.

Dosage: *Adults:* 1 teaspoonful (5 cc.) q12h.
Children (6-12 *years*): ½ teaspoonful q12h.

Side Effects: Minimal, but when encountered may include jitteriness, nausea, drying of mouth, insomnia, constipation, which disappear upon adjustment of the dose or discontinuance of treatment.

Precautions and Contraindications: For complete detailed information, refer to package insert or official brochure.

Strasenburgh

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(Continued from Page 500)

new leadership, new idealism and new intelligence. She encouraged the women to become more involved, and to listen to the candidates carefully.

I was in New Orleans October 10 and 11, attending the Regional Workshop with Ruth Johnson, our President-Elect; Mary Hand, Health Careers Chairman; and Tallie Dillard, AMA-ERF Chairman. This, too, was an excellent meeting, and much was learned to help us to be better informed leaders. One statement made by a speaker has remained with me: "Blessed is the leader who develops leaders while leading." Another speaker said "Evaluate the needs in your community; leave your mark in your community. Will it be a better place because you have been there?"

The Southeast District meeting, held on October 17 at the Opp Country Club, was a real Workshop, which reflected the time and preparation of the members responsible.

"I Enjoy Being a Girl" is one of the hit songs of "The Flower Drum Song." I enjoy being an Auxiliary member, and the more meetings I attend, the more doctors' wives I meet, the more I enjoy it.

Louise M. Wilson

(Mrs. Robert K. Wilson, Sr.)
President WAMASA

Books Of Professional Interest

In choosing a book to commend especially to Alabama doctors as interesting reading outside their scientific journals, two arouse equal enthusiasm:—

THE PERSON IN THE WOMB, by N. J. Berrill, Dodd, Mead, New York, 187 pages—$5.00.

Dr. Berrill writes as both a scientist and a humanitarian in this book that begins with fertilization and a comparison of the human embryo with other creatures, continues with the problems of recessive genes, of sex determination, of safety in the womb from outside attack of virus, drugs, and radiation; the adventure of getting born, the development of the infant, and the prospects of the child in the brave new world in which it arrives, its prospects in the light of present-day scientific experimentation, its inherited disease-bearing genes, the use of drugs, the ominous influences of protein deficiencies, and current efforts to counteract them.

In summation Dr. Berrill insists that "no child must be born without hope, no woman must bear a child against her will, and the sons of men must not overwhelm the earth."

THE YOUTH DOCTORS, by Patrick M. McGrady, Jr., Coward-McCann, New York, 352 pages plus 16 pages of photographs—$7.95.

"Society is ripe for rejuvenation," writes the author early in his book. "Even more to the point, rejuvenation may soon be ripe for society."

From the prescribed "bottled concentration of the breath of five virgins" and Ponce de Leon's pursuit of the Fountain of Youth, ways of postponing or erasing old age or of restoring youth have been the pursuit of research, the inspiration of the charlatan, and the dream of everyone.

In a definitive book on the subject, the author explores in depth the history of those who would recapture or retain youth, either for self or for others, his book digesting his findings from medical libraries and book stores in a dozen countries to interviews with hundreds of rejuvenationists, gerontologists, professors, and scientists engaged in the conquest of age, along with the youth doctors' clients and critics.

In brief, this former Moscow correspondent for *Newsweek* has here in text supported by pictures the story of the people who want to stay young and the doctors who try to keep them that way.

W. J. M., Jr.



Getting her down presents no problem

Even though rauwolfia-thiazides have failed to give control, chances are her hypertension will respond to Esimil. It offers the potency of guanethidine tempered with hydrochlorothiazide.

He's coming down uneventfully

The addition of hydrochlorothiazide makes guanethidine easier to handle, hypertension easier to control. Doses of components are smaller than would be needed if either component were used alone. Side effects are often minimized.

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tempered potency

Esimil®

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hydrochlorothiazide 25 mg

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INDICATIONS

Hypertension which cannot be adequately controlled with simpler agents; moderate to severe hypertension; sustained hypertension; almost all forms of fixed and progressive hypertensive disease; when side effects of other antihypertensives prevent effective treatment.

CONTRAINDICATIONS

Guanethidine: Proven or suspected pheochromocytoma; hypersensitivity to guanethidine. Do not use with MAO inhibitors.

Hydrochlorothiazide: Anuria; progressive renal or hepatic disease; allergy to thiazides or other sulfonamide-derived drugs.

WARNINGS

Guanethidine: Orthostatic hypotension may occur early in treatment, on arising, during hot weather, and after alcohol, prolonged standing, or exercise. Caution patient to sit or lie down with the onset of weakness or dizziness.

Concurrent use with rauwolfia derivatives may cause bradycardia, mental depression, and postural hypotension.

Withdraw therapy 2 weeks prior to surgery if possible to reduce hazard of cardiac arrest or arrhythmia. If not, administer preanesthetic agents, anesthetics, and vasopressors cautiously in reduced dosage with oxygen and atropine ready for immediate use.

Febrile illness may reduce dosage requirements.

Due to catecholamine depletion and increased responsiveness to norepinephrine, special care is required when treating patients with a history of bronchial asthma.

Hydrochlorothiazide: Small bowel stenosis, with or without ulceration, has been associated with use of enteric-coated thiazides with potassium, and with enteric-coated potassium alone. Coated potassium should be used only when dietary supplementation is not practical and discontinued if gastrointestinal symptoms arise.

Titrate dosage carefully in patients with impaired renal or hepatic function or nitrogen retention; discontinue thiazides if progressive insufficiency is observed.

Thiazides may decrease glucose tolerance; use cautiously in diabetics. Hyperuricemia may occur but is readily reversed by uricosuric agents.

Thiazides may decrease arterial responsiveness to norepinephrine and increase responsiveness to tubocurarine. Hypotensive episodes under anesthesia have been observed; decrease dosage of preanesthetic and anesthetic agents.

The possibility of sensitivity reactions should be considered in patients with a history of allergy or bronchial asthma.

Use in Pregnancy

Guanethidine: The safety of guanethidine for use in pregnancy has not been established; therefore, this drug should be used in pregnant patients when, in the judgment of the physician, its use is deemed essential to the welfare of the patient.

Hydrochlorothiazide: Thiazides cross the placental barrier and appear in breast milk. Thus, adverse reactions seen in the adult may occur in the newborn.

PRECAUTIONS

Guanethidine: Give cautiously to patients with severe coronary insufficiency, recent myocardial infarction, or cerebrovascular insufficiency and with extreme caution in those with severe congestive failure. Peptic ulcers and some other chronic disorders may be aggravated by guanethidine.

Appetite suppressants (amphetamines) and mild stimulants (*eg*, ephedrine, methylphenidate) may decrease the hypotensive effect of guanethidine.

Wait one week after discontinuing MAO inhibitors before starting guanethidine.

Periodic blood counts and liver function tests are advised during prolonged therapy.

Hydrochlorothiazide: Monitor indicated blood chemistry and fluid and electrolyte balance carefully in patients on thiazide therapy, especially when patient is vomiting, receiving parenteral fluids, steroids, or digitalis. Supplemental potassium and nonrigid salt intake will help prevent hyponatremia, hypochloremic alkalosis, and hypokalemia.

ADVERSE REACTIONS

Guanethidine: Dizziness, weakness, lassitude, syncope, bradycardia, increase in bowel movements, diarrhea, inhibition of ejaculation, fluid retention, edema, congestive heart failure. Less frequently: dyspnea, fatigue, nausea, vomiting, nocturia, urinary incontinence, dermatitis, scalp hair loss, dry mouth, rise in BUN, ptosis of the lids, blurring of vision, parotid tenderness, myalgia, muscle tremor, mental depression, chest pains (angina), chest paresthesias, nasal congestion, weight gain, and asthma in susceptible individuals.

Hydrochlorothiazide: Anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic), pancreatitis, hyperglycemia, glycosuria, muscle spasm, weakness, restlessness, dizziness, vertigo, paresthesias, headache, xanthopsia, purpura, photosensitivity, rash, urticaria, necrotizing angiitis, leukopenia, thrombocytopenia, agranulocytosis, aplastic anemia. Orthostatic hypotension may occur and may be potentiated by alcohol, barbiturates, or narcotics. Whenever adverse reactions are moderate or severe, reduce dosage or withdraw therapy.

DOSAGE

Optimal dosage must be determined for each individual. *Note:* 10 mg guanethidine monosulfate present in Esimil is equivalent to 8.4 mg guanethidine sulfate USP (Ismelin®).

SUPPLIED

Tablets (white, scored), each containing 10 mg guanethidine monosulfate and 25 mg hydrochlorothiazide; bottles of 100.

Before starting therapy, consult complete product literature.

CIBA Pharmaceutical Company
Summit, New Jersey

2/3832-R1

She's down
o stay

lerance rarely develops with
imil, even after prolonged
e. Because an Esimil regimen
easy and convenient (usually
st one or two tablets
ce a day), the patient is less
kely to skip medication.



Editorial COMMENT

A Happy, Healthy Christmas Wish For Doctors . . . And Their Patients

Christmas is something different for doctors.

For the little people it is a time of tinsel and glitter, of decorated trees and holly wreaths, of the annual reading of "'Twas the Night Before . . ."—and of Santa Claus.

For the grownups it is a time of gaiety and happiness, of gift-giving and worship, generally a return in memory and in spirit to childhood.

For employee and employer, it is usually a holiday.

For other occupations—industries, businesses and professions—it is the same.

But Christmas is something different for doctors.

You'll remember 6-year-old Jimmy. Asked by his Sunday School teacher: "And, what are you going to give your little brother for Christmas this year?" he responded:

"I dunno. I gave him measles last year."

And outside the family, whose Christmas was interrupted by it? Right!

Christmas is something different for doctors.

So it is a different kind of wish that the entire staff of the Medical Association of the State of Alabama extends to every M. D. and his family for this Dec. 25th:

May all his patients remain well—and may his happiness be uninterrupted by the unhappiness of others!

Happiness to him—and health to his patients!

The muscle relaxant that works before you write a prescription

Relieve painful skeletal muscle spasm in your office in minutes with a single 2 cc. injection of NORFLEX. Then, for sustained relief, write a prescription for NORFLEX tablets, 1 tablet b.i.d.

CONTRAINDICATIONS: Due to its anticholinergic action, NORFLEX should not be used in patients with glaucoma, pyloric or duodenal obstruction, stenosing peptic ulcer, prostatic hypertrophy or obstruction at the bladder neck, cardiospasm (megaesophagus) and myasthenia gravis. Use with caution in patients with tachycardia. Do not use propoxyphene (Darvon®) concurrently.

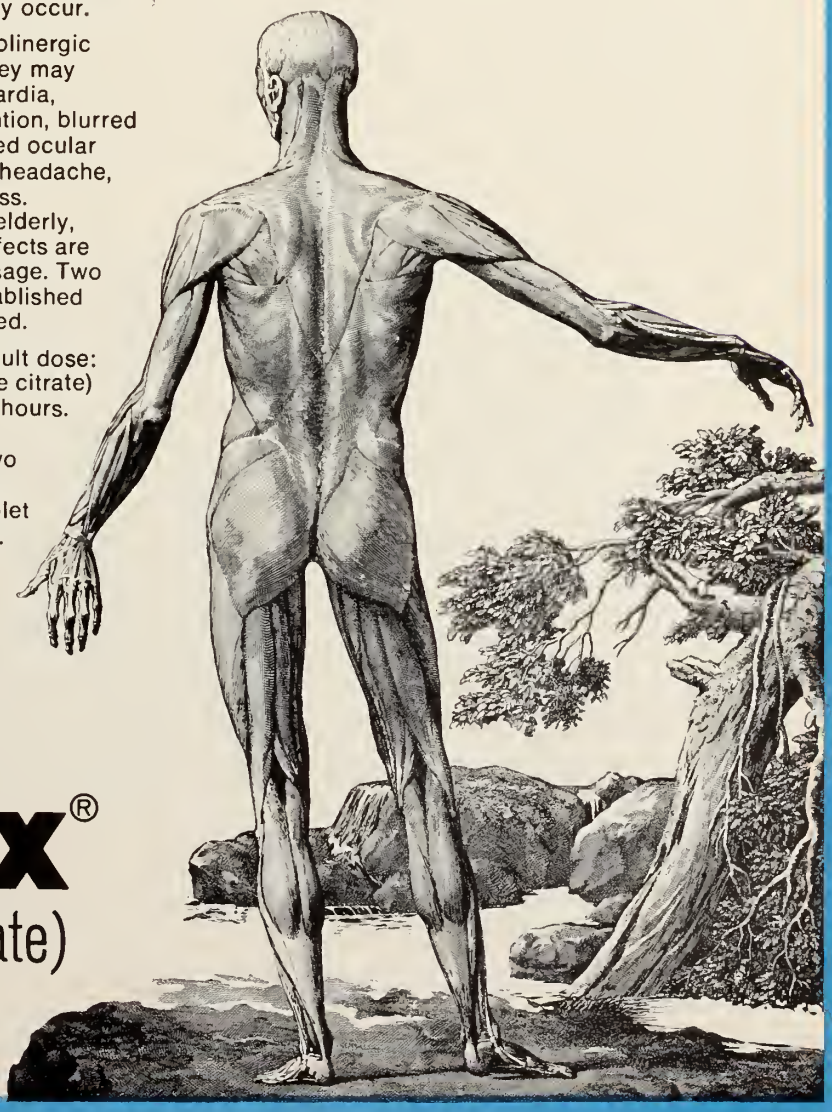
WARNING: Transient lightheadedness or dizziness following NORFLEX-INJECTABLE may occur.

SIDE EFFECTS: Due mainly to anticholinergic action and usually at high dosage. They may include dryness of the mouth, tachycardia, palpitation, urinary hesitancy or retention, blurred vision, dilatation of the pupil, increased ocular tension, weakness, nausea, vomiting, headache, dizziness, constipation, and drowsiness. Infrequently, mental confusion in the elderly, urticaria or other dermatoses. Side effects are usually eliminated by reduction in dosage. Two cases of aplastic anemia, with no established causal relationship, have been reported.

DOSAGE: **INJECTABLE** — Average adult dose: one ampul, 2 cc. (60 mg. orphenadrine citrate) I.M. or I.V. May be repeated every 12 hours. Relief may be maintained with one NORFLEX tablet b.i.d. **TABLETS** — Two tablets per day for adults, one in the morning, one in the evening. Each tablet contains 100 mg. orphenadrine citrate.

For full information, see Package Insert or P.D.R.

Riker Laboratories
Northridge, California 91324



Norflex®
(orphenadrine citrate)

Either Way You Pay

Elsewhere in this issue President E. L. McCafferty, Jr., has touched on problems created by the steadily mounting number of malpractice suits being filed across the nation. No simple solution exists to this problem, else a medical society in a state where it has reached crisis status would be using it.

President McCafferty outlines several approaches which, after careful deliberation, may contain a long-range escape from the dilemma. In the meantime, physicians must realize that an avalanche of malpractice complaints—even the n u i s a n c e variety—will prove costly to them in one way or another. Even though they may win the litigation in a court of justice, the cost of defending the claims will inevitably be reflected in higher and higher insurance premiums.

Until a permanent answer is found, Alabama physicians would be wise to heed the advice recently promulgated by the Malpractice Insurance and Defense Program of the Medical Society of the State of New York entitled "The Facts . . . And Nothing But the Facts." Here it is:

"You are likely to be called upon occasionally to report and to testify in personal injury cases and at Workmen's Compensation hearings.

"Both your written reports and oral testimony should be objective and factual. Should you be required to render an opinion concerning treatment by a previous physician, make sure that you have all of the material facts concerning the conditions that the prior physician was faced with and the details of his treatment. Statements by lay persons concerning examination, diagnosis and treatment, though made in good faith, can be misleading due to unfamiliarity with the technical aspects of the practice of medicine.

"Do not become an advocate for your patient; that is the function of his attorney.

"Beware of unintentionally stretching the facts as to extent of injury or causal relationship; competent counsel for the other side can use this to embarrass you."

Who Shall Inherit The Heart?

You may will your personal property to whomever you wish. But under common law, in the absence of any statute, you may not will your *person,* legal counsel for the American Medical Association agree, weighing the merits of a code for transplants approved by the American Bar Association.

A "uniform anatomical gift code" was completed by the National Conference of Commissioners on Uniform State Laws, approved by the ABA, and is now being considered by the AMA Board of Trustees. Thirty states have adopted statutes dealing with the subject, most of them, according to Prof. William J. Pierce of the U. of Michigan, president of the conference of commissioners, "less than comprehensive and adequate."

The proposed code would authorize the gift of the whole body or part of it for scientific and therapeutic use, medical schools, tissue for medical research, and all types of transplants, including cornea, bone, skin, and organs. While not aimed specifically at heart transplants, it is broad enough to include them.

The proposed code sets up priorities, certifies a list of acceptable donees, and even notes that "the donee may accept or reject the gift."

We have come a long way since cadavers were obtainable only at night and from the fresh graves of cemeteries. We probably have a long way to go before the medical profession at a state level agrees to a fixed code for the gift of bodies and parts of bodies.

Pleasure Cuts Deeply Into Most Medical Society Meetings

Unless the subject is sex, most meetings of medical groups at a state or national level enjoy only token attendance, while the physicians play golf, attend shows, and busy themselves generally with pleasant diversions, according to Dr. Irvine H. Page, editor of Modern Medicine.

According to Dr. Page, ". . . commercial exhibits, women's auxiliaries, door prizes, committee meetings, golf tournaments, breakfasts, delegate meetings, shopping, and shows and such like are downgrading the intellectual content of our professional meetings. . . . Too often the members only read in the newspapers what was presumably presented at the meeting. The scientific program is something to be endured rather than savored. Speakers seldom do their best in such an atmosphere of indifference.

"There are, of course, many meetings in which this is not true, but these are usually the small ones and largely for specialists or academicians. This is more the pity because it is the bulk of physicians confronted with the multiple problems of medicine who need stimulation and education most: for example, those who attend chiefly the state society meetings where too often the intellectual content is adequate but, as someone said, boredom is as plain as the dozes on their faces.

"Physicians do indeed need both a forum and a cocktail lounge to discuss their political views. Their wives enjoy the activities of auxiliaries, the pharmaceutical manufacturers need a place to exhibit their wares. But in all the hubbub, the speaker's message is lost. He is becoming something to be tolerated, a holdover from a vanishing milieu."



PHYSICIAN PLACEMENT SERVICE IN ALABAMA

The Physician Placement Service of the Medical Association of the State of Alabama is designed to assist both physicians and communities. MASA members having knowledge of practice opportunities or wishing to relocate their own practices are urged to communicate with the Placement Service. For further information: write Mr. Emmett Wyatt, Executive Assistant, Medical Association of the State of Alabama, 19 South Jackson Street, Montgomery, Alabama 36104, or Telephone 263-6441.

Locations Wanted

General Practice—

Age 44, Medical College of Alabama, 1967, seeking associate practice in town of 12,000 plus population in central or south Alabama. LW-1

Age 56, Georgetown University 1938; seeking solo, group or associate practice, with general surgery. LW-2

Age 52; University of Chicago 1950; seeking group, industrial, institutional or student health position. LW-3

Age 31, Western Reserve, 1964; seeking group, associate or institutional practice. LW-4

Age 38; University of Oklahoma, 1955; seeking associate, institutional or industrial practice; in town of 10,000 plus population; interest in surgery. LW-5

Age 28; Medical College of Alabama 1966; seeking practice in town of less than 14,000 population to fulfill scholarship requirements. Available 1968. LW-6

Age 28; University of Tennessee, 1965; available November 1968. LW-7

Internal Medicine—

Age 36, Medical College of Alabama, 1963; seeking solo, group, or associate practice. LW-8

Age 34; University of Mississippi 1960; Board eligible; seeking location in southern section of Alabama in city of 15,000 plus population. LW-9

University of Mississippi 1963; seeking group practice in city of 20,000-40,000 population. LW-10

Age 34; Hahnemann Medical College 1959; Board eligible, National Board; seeking solo, group, or associate practice. Available immediately. LW-11

Age 35; University of Tennessee 1958; Board certified; seeking group, industrial or institutional practice. LW-12

Age 37, Duke University, 1956; Board certified, seeking group, associate, or institutional practice. LW-13

Neurology—

Age 32, Medical College of Georgia, 1964, seeking assistant or associate, or institutional practice. LW-14

Age 31; Harvard 1962; Board eligible; National Board; seeking solo, group or associate practice. Available July 1969. LW-15

Age 30; Medical College of Alabama 1962; Board eligible; National Board; seeking solo, group, associate or institutional practice. Available January 1969. LW-16

Age 31; University of Virginia 1962; Board eligible; seeking associate or group practice. Available August 1969. LW-17

Obstetrics-Gynecology—

Age 35, Vanderbilt University, 1950. Board eligible. LW-18

Age 49, University of Nebraska, 1943; Board certified, seeking group or institutional practice. LW-19

Age 34, Medical College of Virginia, 1961, Board eligible, seeking group or associate practice. LW-20

Age 33; University of Illinois, 1964; seeking associate practice. LW-21

Radiology—

Age 39; Louisiana State University 1954; seeking solo or associate practice. Available July 1969. LW-22

Age 31; S. U. N. Y. College of Medicine, 1961; Board eligible; seeking solo, group, or associate practice. LW-23

Age 41; Cornell Univ. Medical School, 1953; Board certified; seeking group, or associate practice. Available immediately. LW-24

Age 51; Univ. of Texas Med. Branch, 1942; Board certified; seeking solo, group, or associate practice. LW-25

Surgery—

Age 30; Duke University School of Medicine, 1964; seeking location in larger cities. LW-26

Age 33; University of Missouri, 1961; seeking group or associate practice. Available January 1969. LW-27

Age 38; Emory University, 1956; Board eligible, seeking group, associate, or institutional practice. LW-28

Age 37; Faculty of Medicine, Manitoba, 1957; Board certified; seeking associate or institutional practice. LW-29

Age 34; University of Santo Tomas, 1961; Board eligible, seeking group or associate practice. LW-30

Age 35; University of Santo Tomas, 1956; Board eligible, seeking solo, group or industrial or associate or institutional practice. LW-31

Urology—

Age 30; Louisiana State University, 1963; Board eligible, seeking associate, or group practice. LW-32

Physicians Wanted

General Practitioners—

Opportunity in town of 4,000 population in trade area of 50,000 population, located within 100 miles of two metropolitan areas in south Alabama. Industrial and farming area. 44-bed hospital. Office space and equipment available in new building with another physician. Several churches, schools, and service clubs. PW-1

Opportunity for group practice in town of 10,000 population in north Alabama. PW-2

Physician wanted to join 39 year old Medical College of Alabama graduate in a well established general practice in West Central Alabama town. Salary initially followed soon by full partnership. PW-3

Opportunity in community of 5,000 population in trade area of 30,000 population located in northeast Alabama where at present time there are only two active full time general practitioners. Modern offices or clinic facilities available. 48-bed accredited hospital and 52-bed skilled nursing home adjoining the hospital. Cities of approximately 75,000 population located within 25 miles distance. Agricultural and expanding industrial area. Numerous churches and schools. Country club and golf course being developed and water sports and outdoor activities offer recreational advantages. PW-4

For town of 2,000 population in trade area of 5,000 located in South Alabama, within 24 miles of large city of 37,000 population. Nearest hospital (50 beds) is 12 miles away. One physician presently in practice in town. Office space available. Military base, farming, and small industries afford resources. Numerous civic clubs, two schools, and five churches. PW-5

For town of 4,500 population in trade area of 10,000 to 15,000 with annual payroll of 4½ million dollars, located in north central Alabama. Within 75 and 85 miles respectively of two metropolitan areas with combined population of 2 million. Hospital privileges available in modern 30-bed hospital. A modern 40-bed extended care facility adjoins hospital. Excellent churches, schools and shopping areas. In the center of the best hunting, fishing and recreational area in the state. PW-6

Physician wanted to join well established partnership in Northwest Alabama city of 15,000 population. Two accredited hospitals, junior college, schools, churches, recreational activities. No obstetrics or surgery. New office building. PW-7

For city of approximately 15,000 population in north Alabama, with trade area of approximately 45,000 population. Hospital with over 100 beds, and expansion planned for next year. Nursing homes in the area. Industrial growth and agricultural region. Several churches and schools. Golf course, civic and fraternal organizations. PW-8

For partnership practice in clinic in town of 2,000 population in area of 10,000 population located in north-central Alabama. 40-bed hospital. PW-9

For assistant or associate in clinic located in town of 10,000 population located in northeast Alabama. 65-bed Hill-Burton hospital. PW-10

For associate practice in city of 6,000 population in area of over 10,000 population located in East-central Alabama. PW-11

For solo practice in county clinic located in East-central Alabama. Office, equipment and housing available. 70-bed Hill-Burton Hospital and 22-bed nursing home. PW-12

For town in southwest Alabama, approximately 1,000 population in trade area of approximately 5,000 population, within 60 miles of large city of 35,000. Nearest hospital is located 18 miles away. Arrangements available for office space. Small industries and agriculture. Civic clubs and golf course nearby. Churches and school. PW-13

For town of approximately 1,000 population in population center of 10,000 located in Southwest Alabama within 90 miles of the Gulf coast. City owned clinic is offered rent free and fully equipped. Hospitals are located in two nearby towns within 25 miles. This is principally an agricultural region, but there are military installations nearby. Numerous civic clubs, community concert series, and a country club offer recreational activities. PW-14

For town of 1,000 plus population in west-central Alabama in trade area of 20,000. Clinic available. Nearest city of approximately 70,000 population is located a distance of 17 miles. Farming, cattle, timber, and manufacturing plants are principal resources of the area. Churches, schools, and recreational advantages. PW-15

Opportunity for general practitioner to join a five-man group, practicing as a partnership. Each man in the group is either specialized or semi-specialized. The practice is physically located within a 70-bed hospital. Willing to pay qualified person $36,000 for the first year, with possible partnership status in one year. Would consider a physician for locum tenens for three to six months at $2,000 per month. PW-16

For town of 3,600 population in trade area of 5,000-7,000 within 100 miles of two large cities and the Gulf Coast. 50-bed hospital located in the town. Office space available. Agricultural and expanding industrial area. Several churches and two schools. Recreational activities in the town as well as nearby—golf course, hunting and fishing. PW-17

Unusual opportunity for two general practitioners with military obligations satisfied at a modern fifty bed facility located 15 minutes drive from largest metropolitan center in north-central Alabama. Construction of a new two-story office building is scheduled to begin soon. PW-18

Opportunity in city of 5,000 population located in Northeast Alabama in trade area of approximately 10,000 population. Office space available. One physician died recently. Hospital and nursing home in the city. PW-19

(Continued on Page 516)



pinworms in this school?

possibly, because hygienic measures alone, however meticulous, may not prevent the spread of pinworm infections which are estimated to occur in from ⅓ to more than ½ of all American children from every social level

REMINDER: Because pinworm infections spread easily and quickly in families, schools, and institutions, multiple infections among primary groups seem to be the rule rather than the exception. For successful management, it is desirable to check all exposed members of the family or play group. The *single-dose efficacy* of POVAN makes therapy entirely practical, convenient, and economical.

INDICATION: Pinworm infection.

PRECAUTIONS: Tablets should be swallowed whole to avoid staining teeth. Pyrvinium pamoate will stain most materials. Stools may be colored red.

ADVERSE REACTIONS: Nausea, vomiting, cramping, and diarrhea have been reported.

POVAN is available in suspension or tablet form. The pleasant-tasting, strawberry-flavored suspension contains the pamoate equivalent of 10 mg. of pyrvinium base per cc., in 2-oz. bottles. The sugar-coated tablets each contain the pamoate equivalent of 50 mg. of pyrvinium base, bottles of 25.

When examination reveals pinworm infection—an increasing number of physicians favor treatment with a single, well-tolerated dose of—

Povan®
(pyrvinium pamoate)

PARKE, DAVIS & COMPANY, DETROIT, MICHIGAN 48232

PARKE-DAVIS

44768

Physicians Wanted

(Continued)

Special Openings—

Specialist in the following fields: Internal Medicine, Pediatrics, Obstetrics-Gynecology and General Practitioners. 58-bed fully accredited general hospital with 91-bed addition recently completed. Modern new office space available. PW-20

Opportunity for general practitioners or internists for institutional practice at TB Sanatorium in North Alabama. PW-21

Opportunity for physician interested in joining a progressive public health tuberculosis control program working in Birmingham, Jefferson County. Provide outpatient medical services and some administrative duties. Fringe benefits and salary open. PW-22

Student Health—

New 75-bed facility to be occupied in late 1968. Present staff of seven full-time physicians. Salary negotiable. Appointments are full time with regular University benefits. PW-23

Full time salaried position of assistant director on staff of four 65-bed well equipped infirmary with adequate office space. Excellent laboratory and X-ray facilities. Liberal fringe benefits. PW-24

Obstetrician-Gynecologist—

Excellent opportunity for a trained Ob-Gyn man who would join a three-man partnership practice in city of 30,000 population located in southwest Alabama. Salary is proposed for the first 12 months, a limited partnership to begin at the end of twelve months, and full partnership to begin at the end of 24 months. PW-25

Medical Education Program Launched in Montgomery

A medical educational program that hopes to grow in time into an internship and residency for Montgomery, as a satellite of the Medical Center in Birmingham, is being launched this month auspiciously with Dr. Tinsley R. Harrison, professor emeritus and one of the nation's leading teachers of medicine, spending two days a week in Alabama's capital city.

The Medical Society of Montgomery County had three speakers up from Pensacola for the November meeting to explain their extensive educational program and facets of this Florida plan will be adopted by the Alabama city. Dr. H. Hamilton Hutchinson, chairman, for St. Margaret's; Dr. Jack Kirschenfeld, for Baptist; and Dr. George Blue Penton, for Jackson, were appointed by county society President Dr. Ross McBryde as a committee in charge.

Optionally, seniors from the Medical College of the University of Alabama may spend part of the school year here, or they may spend their vacation time exploring what the Montgomery program has to offer. In other words, the individual student may spend either his elective time or his "free time" in this clerkship.

Under present plans, Dr. Harrison will spend Mondays and Tuesdays here, and the course will offer eight concentrated hours in which the senior will lunch with Dr. Harrison and with the staff make the hospital rounds with him. During December, visits will be made to Baptist Hospital; in January to St. Margaret's.

The remaining five days of the week, instruction and tours will be by prominent Montgomery doctors.

Refusing to accept full retirement, despite a health condition, Dr. Harrison some time ago began teaching several students through the Russell Hospital in Alexander City. It proved a successful innovation, an act of imagination and generosity on the part of Dr. Harrison, and his agreement to teach two days in Montgomery is a further expansion of his idea.

Not only will the medical educational program for Montgomery open the way to internship and residency, but it will provide a way of continuing education for the medical profession in the capital city and surrounding areas.

A Built-In 'Policeman' Watches Out For Speed And 'Pep' Pills

Just as a "mechanical brain" is coming up with simple answers to some of our more complex problems, so is a "mechanical tattletale" helping to make the highways of our nation safer.

In the determined pursuit of accident causes, evidence indicts speed and the use of "pep" pills as contributing their share and more of the worst traffic accidents in our nation's history. A vehicle driven by a speed-demon is a lethal projectile, or driven by a drugged driver one of the most deadly of road hazards. In consequence, many truck-fleet operators have made speeding and the use of drugs firing offenses on their truck routes.

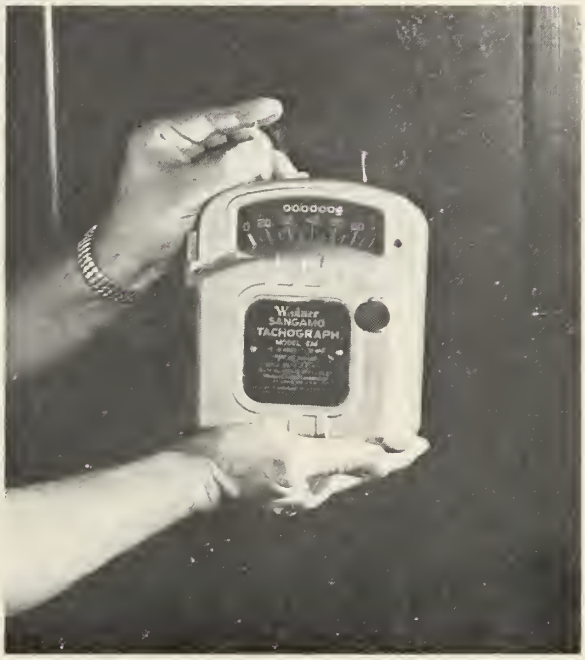
An example is the Whitfield companies in Montgomery, who truck their products—Alaga Syrup and Whitfield Pickles—to every corner of the continental United States in a fleet of huge trailers pulled by 26 powerful tractors.

Some are driven by a single expert driver, others by a team of two; and it is not unusual for a Whitfield truck to travel loaded 2,000 miles from Montgomery, non-stop except for refuelling. One driver sleeps in a bunk in the roof of the cab, while the other is at the wheel.

And riding in each of these trucks is a mechanical tattletale!

Did this truck break the speed limit, anywhere along the route? Did it go 60 miles an hour through a 45-mile zone, or 70 miles an hour on the open road, where the speed limits are 60? Was the truck braked to a sudden stop, indicating an unexpected traffic crisis? Was the speed steady or erratic?

The compact little machine, known officially as a "Tachograph," tells all, and it is as readily insurance for the law-abiding truck driver as it is the Nemesis of the offender. Introduced as evidence in a traffic accident it contradicted sworn testimony that the truck was speeding, and the court upheld its contradiction.



The "Tattletale" and the pin that failed to outwit it.

And the Tachograph hasn't yet been outwitted by those it tattles on! The hands holding the Tachograph in the accompanying picture are those of James D. Lynch, Whitfield assistant vice president in charge of transportation. The safety pin he is holding between his thumb and forefinger is the instrument with which one driver sought to outwit the machine. He had punctured the panel of his Tachograph with the pin to stop the speed indicator needle at 60—which was the top speed limit at that time. The pin had done its job—and the driver was innocently unaware that a tape inside was faithfully recording the true speed of his vehicle!

Periodically, the Tachographs are returned to the factory for recalibration. Otherwise they are in continual service.



Summation:
In addition to its primary indications for duodenal and gastric ulcer, Robinul Forte (glycopyrrolate) is indicated for other G-I conditions that may benefit from anticholinergic therapy. Robinul-PH Forte (glycopyrrolate 2 mg. with phenobarbital) is indicated when these situations are complicated by mild anxiety and tension.

Contraindications: Glaucoma, urinary bladder neck obstruction, pyloric obstruction, stenosis with significant gastric retention, prostatic hypertrophy, duodenal obstruction, cardiospasm (megaesophagus), and achalasia of the esophagus, and in the case of Robinul-PH Forte, sensitivity to phenobarbital.

Precautions: Administer with caution in the presence of incipient glaucoma.

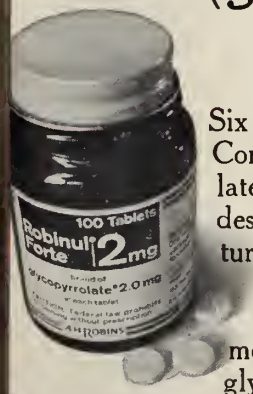
Adverse Reactions: Dryness of the mouth, blurred vision, urinary difficulties, and constipation are rarely troublesome and may generally be controlled by reduction of dosage. Other side effects associated with the use of anticholinergic drugs include tachycardia, palpitation, dilatation of the pupil, increased ocular tension, weakness, nausea, vomiting, headache, dizziness, drowsiness, and rash.

Dosage: Should be adjusted according to individual patient response. Average and maximum recommended dose is 1 tablet three times a day; in the a.m., early p.m., and at bedtime. See product literature for full prescribing information.

Supply: Robinul (glycopyrrolate 1 mg.): Robinul Forte (glycopyrrolate 2 mg.): Robinul-PH (glycopyrrolate 1 mg.) with phenobarbital 16.2 mg. (Warning: may be habit forming); Robinul-PH Forte (glycopyrrolate 2 mg.) with phenobarbital 16.2 mg. (Warning: may be habit forming), in bottles of 100 and 500 tablets. A. H. Robins Company, Richmond, Va. 23220.

A·H·ROBINS

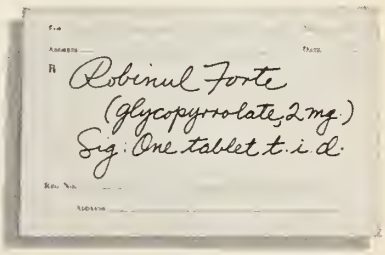
In peptic ulcer therapy, won't you give Robinul® Forte a Fair Trial?
(glycopyrrolate)



Six years ago the A. H. Robins Company introduced glycopyrrolate, a unique anticholinergic agent described in the prescribing literature as more closely approaching the ideal compound for controlling gastric hyperacidity and hypermotility of the G-I tract. Although glycopyrrolate (Robinul Forte) found good acceptance among numerous physicians, many others just didn't seem to want to give it a try, probably because the anticholinergic they were already using was giving acceptable results.

However, we believe you'll agree there's always room for a better anticholinergic. This is why we're asking you to give Robinul Forte a fair trial. Robinul Forte exerts a highly specific antisecretory action and marked inhibitory effect on intestinal tone. We're convinced you'll agree that this is indeed an outstanding drug when you observe its outstanding suppression of ulcer symptoms. Furthermore, it is unique in that it reduces intestinal tone, yet has little or no effect on peristalsis. In addition, the incidence of the more bothersome peripheral side effects is low.

No longer does the physician have to look for extreme dry mouth as the measure of his anticholinergic's effectiveness. The only way we can demonstrate to you firsthand the efficacy of glycopyrrolate (Robinul Forte) is for you to try it in your practice. That's why we're asking you to give it a Fair Trial. How can you give it a Fair Trial? You do it this way:



First: When you see your very next ulcer patient, write him a script as shown.

Next: Wait 10 days or until your patient comes in for his next appointment and get his "verdict" as to how he feels. Examine all the evidence and make your evaluation of his condition.



Finally: Render **your** verdict. If it's "significant improvement and marked relief of symptoms," then we believe you'll agree that Robinul Forte has proved its worth, and we rest our case. If not, consider our case for Robinul Forte closed. That's a Fair Trial, Doctor, and it's all we ask.

Robinul® Forte
(glycopyrrolate, 2 mg.)

The summation is an important part of every case. You'll find ours on the preceding page, Doctor.

Retardation Hospital Named For Governor Who Made It Possible

A day that "belongs to none of us . . . a day that belongs to the memory of Lurleen Burns Wallace, a great governor, . . . a great human being," to borrow the words of Gov. Albert Brewer, was devoted to groundbreaking ceremonies for a mental retardation hospital in Decatur.

While the cabinets of three Governors, members of the legislature, the State Mental Health Board, and other leading citizens looked on, former Gov. George C. Wallace turned the first spade of earth for the $4.2 million Lurleen B. Wallace Mental Retardation Hospital, a 400-bed establishment that is a memorial to the Governor who launched state support of an entirely new concept in the treatment of this kind of mental ill health.

Gov. Brewer pointed out that it was primarily the late Lurleen Wallace who saw the need, interested the legislature, and aroused public opinion to the overwhelming approval of a $15 million bond issue to finance a massive mental health construction program.

Gov. Brewer was paying his first visit home since he succeeded Gov. Lurleen Wallace as the state's chief executive. And Gov. George Wallace was making his first public appearance since election day. Accompanying Wallace were two of his daughters, 7-year-old Lee, who unveiled the portrait of her mother which will hang in the administration building of the hospital complex, and Mrs. James Parsons of Birmingham.

Sim A. Thomas, chairman of the State Board of Mental Health, was in charge of the dedication ceremonies. And, after calling on the Rev. William K. Stephenson for the invocation, Chairman Thomas thanked Gov. George Wallace for initiating support of mental health, and the late Gov. Lurleen Burns Wallace for dedicating her administration to "the relief of these unfortunate people who, through no fault of their own, faced a lifetime of incarceration with no hope of ever knowing the joys of freedom and health."

Chairman Thomas then introduced members of the State Mental Health Board, beginning with the first chairman, Frank Moody of Tuscaloosa, and the second chairman, Dr. Robert Parker of Montgomery, and continuing with Judge Bernard Reynolds, Selma; Dr. John A. Martin, Montgomery; Ed T. Hyde, Talladega; Dr. Claude L. Brown, Mobile; Dr. Paul W. Burleson, Birmingham; Senator Robert T. Wilson, Jasper; Dr. John Chenault of Decatur; and the two newest additions to the board, Carl Boley of Sheffield, and Dr. Hugh Gray, Anniston.

Mr. Thomas introduced Dr. Chenault, who as master of ceremonies presented the guests of honor—the members of Wallace family, members of the three Governors' cabinets, members of the Legislature, county commissioners, mayors, probate judges, the President of the Medical Association of the State of Alabama Dr. E. L. McCafferty, Jr., of Mobile, board members of the Alabama Association for Retarded Children, the Alabama Association for Mental Health, the new state mental health officer, Dr. Stonewall B Stickney, Barrett Shelton, Sr., as chairman of the board of the Decatur ararngements committee, and finally Probate Judge T. C. Almon of Morgan County, who in turn introduced Gov. Brewer.

The advantage of home in the care and treatment of the mentally retarded is primarily responsible for the locating four mental retardation hospitals in different parts of the state, and plans farther to extend the geographical coverage with other satellite facilities. Thus, as many of the mentally retarded as possible will become outpatients, living at home and coming to their assigned hospital for therapy and guidance.







A HIGHLIGHT of the groundbreaking ceremonies in Decatur for the Lurleen Wallace Mental Retardation Hospital, was the unveiling of Gov. Wallace's portrait by her 7-year-old daughter, Lee. Dr. John Chenault, master of ceremonies, may be seen back of the veil. . . . In the picture at the left are Gov. Albert Brewer, Congressman Bob Jones, State Finance Director Bob Ingram, Public Safety Director Col. Floyd Mann, and other members of Gov. Brewer's cabinet. . . In the picture at the right are Gov. George Wallace with little daughter, Lee (visible just under his right hand), another daughter Bobby Jo Parsons and her husband.

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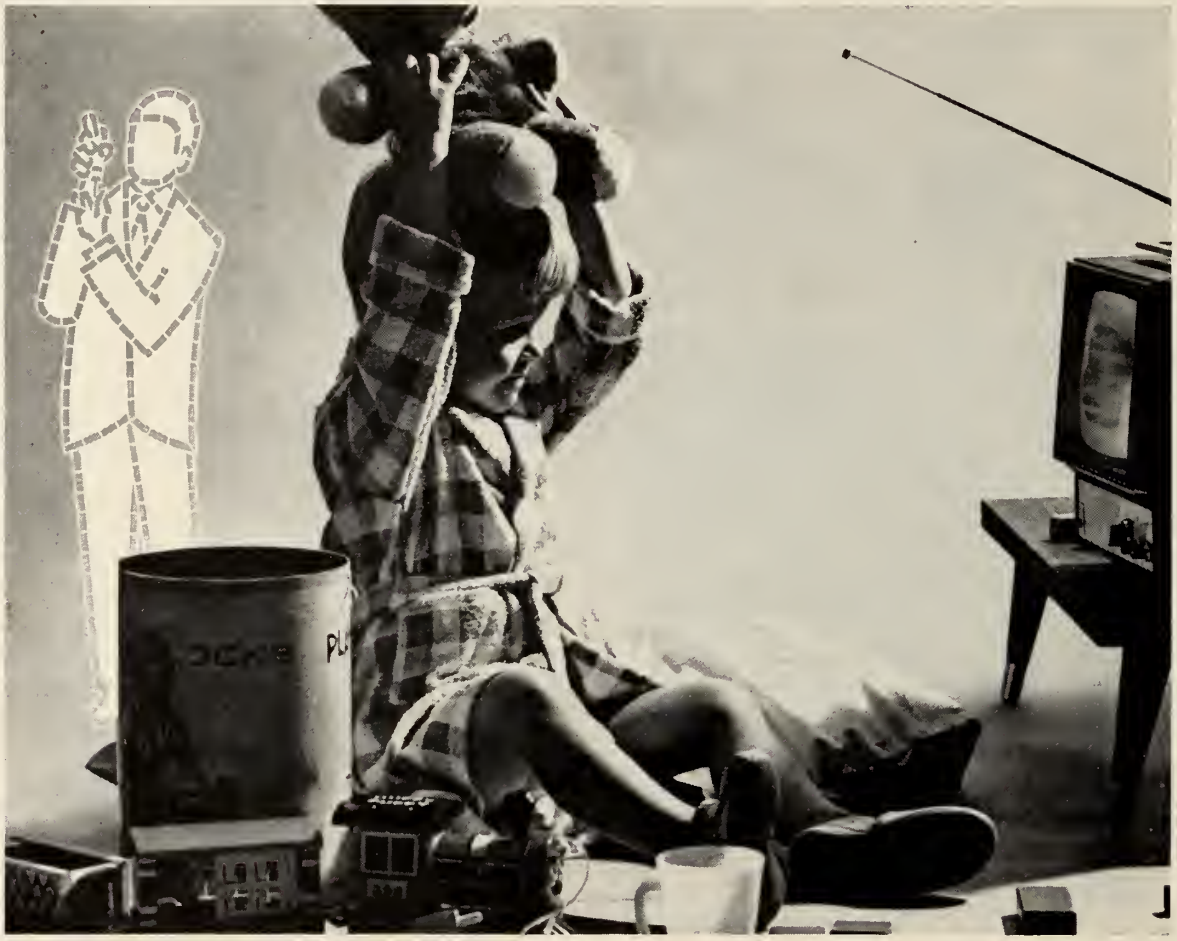
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A Concept Of Surgery For The Prevention Of Strokes

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Atmore, Alabama

Introduction

Vascular surgery occupies an important role in the prophylactic treatment of strokes because the occlusive process is extracranial in about 60 per cent of the cases.[6] The localization of the occlusive process to the carotid and vertebral systems lends itself readily to surgery and combined with the segmental nature of the disease process permits abolishment of the obstructive defect. The realization that a total defect is usually heralded by transient signs and symptoms of a stroke makes this, understandably, a preventable disease. That these "little strokes" are the result of extracranial stenotic lesions is evidenced by the fact that restoration of normal blood flow results in the cessation of the transient episodes.[7]

All too often, the vascular surgeon is asked to see the completed stroke for management. Surgery under these circumstances has been disastrous for the patient and we do not need to repeat these procedures to prove that surgical intervention has little to offer once a cerebral infarct is established.[11, 12] Carefully directed attention to more conscientiously consider the real nature of transient strokes coupled with positive physical findings in the head, neck, or arms will prove rewarding though. Once it has been established that arterial disease exists, it is mandatory to determine the presence of, the nature of, and the location of the obstructive process by appropriate arteriography. Because of this premise, it is essential to review warning symptoms and signs in more detail.

Signs and Symptoms

Arterial insufficiency may involve any part of the brain. The resultant findings will be dependent upon the site and the extent of the occlusive process as covered by compensatory collateral circulation. Typically, unilateral carotid stenosis presents as lightheadedness with transient blindness or blurring of vision on the affected side and is usually accompanied by sensory and motor changes on the opposite side. Aphrasia is likely to occur when the dominant hemisphere is involved. Vertebral artery insufficiency should be recognized because of bilateral visual disturbances accompanied by vertigo, loss of balance and bilateral sensory and motor disturbances. Whenever situations involve both the carotid and the vertebral systems, differentiation is more complex. The most important aspect of the history taking is the realization that transient episodes are almost always the result of arterial insufficiency and precede completed strokes in more than 60 per cent of the cases. Differential diagnoses should include Meniere's syndrome, middle ear disease, Stokes Adams episodes, carotid sinus sensitivity and adverse drug reactions.

Characteristically, transient strokes last from a few seconds to a few hours. A total spontaneous recovery without residual abnormality is the rule rather than the exception. The episodic nature of cerebral vascular insufficiency is poorly understood. Various explanations have been offered such as reduced cardiac output, pressure differentials, and metabolic hypoxic responses that adversely affect collateral flow as well as resistance differentials developing between flow and need. Attacks have been observed to follow myocardial infarctions, hemorrhagic shock, hypertensive therapy and the induction of anesthesia.[3] Embolic lesions from an ulcerated plaque and arterial spasm related to intraluminal dissection or plaque dislodgement are also causes.[1] Hollenhorst's findings of colored mobile plaques in the retinal artery of such patients adds support to these theories.[4] Rapid recovery is explained by marked cerebral vasodilatation developing in response to the brain's anoxia.

The findings of a thrill, a palpable plaque or a localized bruit suggest a significant lesion. A diminished or absent temporal pulse only signifies involvement of the external carotid artery and reliance upon it for interpretation of the presence or absence of internal carotid artery flow is meaningless. Normal carotid artery and upper extremity pulses strongly mitigate against any lesion of significance. Correlation between the intensity of a bruit and the degree of stenosis is difficult. In fact, inverse relationships more likely exist, because a small narrowed vessel gives rise to a loud noise whereas a totally obstructed vessel causes no noise at all. An absent carotid pulse helps to localize the lesion to the respective carotid bifurcation. An absent or diminished brachial artery pulse indicates subclavian or innominate artery disease. If the wrist pulse is altered by ipisilateral carotid artery pressure without significant contralateral change, the presence of a subclavian artery steal is established.

Arterial Studies

Cerebral arteriography is the sine quo non for the proper selection of patients for carotid artery surgery. Arteriography establishes the site and the extent of the obstruction as well as the adequacy of cross-filling and excludes any significant intracranial disease. A small volume of dye, general anesthesia, adequate fluid hydration and serial biplanar roentgenographic techniques have helped reduce the risk of carotid arteriography to a 0.8 per cent stroke incidence of a 0.0 per cent incidence of carotid thrombosis.[5] Whenever "take-off" disease is clinically non-apparent, the rather routine use of right retrograde brachial arteriogram combined with left pericutaneous carotid arteriogram gives an adequate four vessel evaluation. Selective retrograde arteriography with image amplification would appear to afford an even safer and more reliable method of investigation.

Surgery

Surgical correction is indicated for those patients with symptoms of transient cerebral ischemia and physical findings of a carotid artery bruit with angiographic demonstration of a significant extracranial occlusion.[8] Because strokes generally result from carotid or vertebral stenosis rather than brachiocephalic obstruction, we usually have to deal with only two procedures: carotid endarterectomy and vertebral artery angioplasty.

Surgery is indicated for any stenosis of greater than 50 per cent because such a stenosis regularly produces a pressure gradient across that lesion.[2] An exception to this would be in a patient with an obstruction of less than 40 per cent who has transient strokes wherein the surface of the atheromatous plaque is unusually irregular or ulcerated in appearance.[1] Emergency endarterectomy is advisable only if arteriography reveals a hairline opening and the patient's condition deteriorates following angiography. Evaluation is particularly urgent for rapidly progressing symptoms. Evaluation is also urgent when the episodes last longer and

longer and in patients with pin-point or "shutter vision."[11]

If carotid and vertebral stenosis co-exist, the carotid endarterectomy should be done first because the net effect upon cerebral circulation is greater, the operation is simpler and easier to perform, and temporary intraluminal shunting affords better brain protection. Carotid artery surgery is indicated for an asymptomatic patient when the stenosis is significant, when any major surgical procedure is being planned or when a therapeutic reduction of blood pressure is being anticipated. General anesthesia with an intraluminal shunt combined with local or regional heparinization affords the best means available for brain protection.[9]

Carotid endarterectomy is graphically depicted in Figure I and vertebral angioplasty in Figure II. Post-operative anticoagulation therapy should not be employed. The more salient points relating to endarterectomy are: 1). a conveniently placed arteriotomy of sufficient length, 2). an adequate intraluminal shunt to supply 150 to 200 cc of blood per minute which is carefully introduced in order to avoid emboli and filled first from above to protect against air, 3). an appreciation that the plaque terminates just a short ways distal to the bifurcation in the internal carotid artery and that a smooth circumferential excision in the common carotid artery avoids subsequent thrombosis and dissection, 4). an awareness that once the shunt is established, haste is wasteful whereas a meticulous endarterectomy with a distinct cleavage plane is possible, 5). a knowledge that the sequence of flow restoration following endarterectomy is to release the internal carotid clamp first and flush it from above, to reclamp the internal carotid and with the external carotid open, to then release the common carotid in order to flush away, into the external carotid system, any residual debris or air bubbles before re-establishing internal carotid artery flow, and 6). that vertebral artery stenosis must be treated by patch grafting through an adequate vertebral and subclavian arteriotomy rather than by attempting endarterectomy.

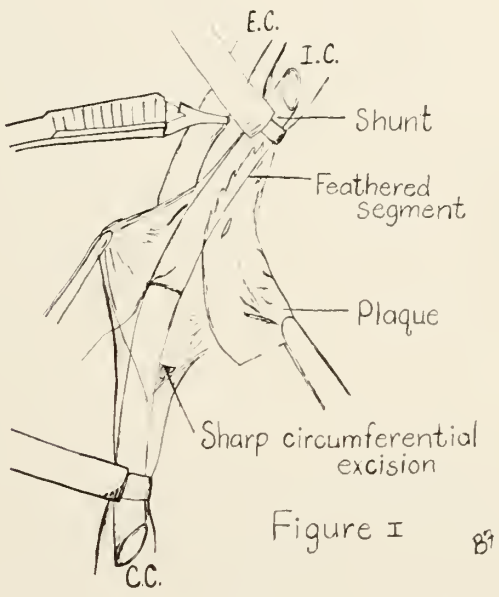


Figure 1

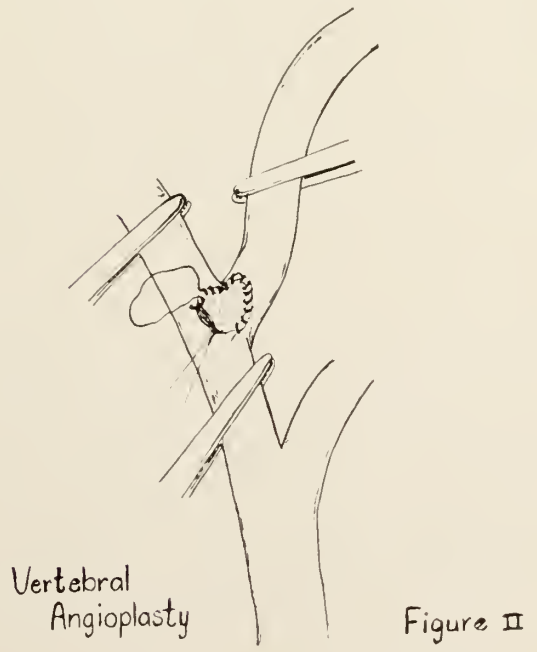


Figure 2

Summary

The bifurcation of the common carotid artery is a rather prevalent site for segmental occlusive atherosclerotic disease. Neglected stenosis at this level leads ultimately to a completed stroke in a large per cent of patients. Most patients with this type disorder can be clinically detected before this occurs through the obtaining of a history of a transient stroke combined with the physical findings of an absent carotid pulse, a palpable plaque or a localized bruit. Arteriography is necessary to establish a hemodynamically significant stenosis and to rule out any associated disorder. The risk of carotid artery surgery is negligible when a properly selected patient is combined with meticulously performed surgery. Carotid endarterectomy is not indicated for a chromic completed stroke, a cerebral infarct, or in the presence of bloody spinal fluid.

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Psychological Aspects Of Cerebro-Vascular Disease As Compared With Those Of Early Infantile Autism

Priscilla A. Keeler, M. D.

Birmingham, Alabama

I am reasonably certain that many of you are wondering why a child psychiatrist should be discussing with you today the psychological aspects of a disease which rarely appears in childhood. Yet, on the other hand, I am equally certain that every one of you has at some time described an elderly person, usually with evident arteriosclerotic cerebral impairment, as being in his "second childhood."

The thought has come to me with increasing persistence that perhaps this term is not as facetious as we usually intend it to be, and that we might do well to study our use of it a little more closely, particularly as it relates to "first childhood."

In general, those whom we describe thus are somewhat disoriented, confused and forgetful, selfish, and frequently at least partially out of contact with their environments. One must wonder why we label this syndrome as "second childhood." Quite obviously, this picture does not describe a *normal* child. Whom, then, does it describe?

There are other questions which come to mind. How can we explain differences of reaction in similarly damaged persons, where one responds to stress with only momentary symptomatology, r a p i d l y regaining his former psychological capacities, while another pursues equally rapidly a down-hill path to irreversible senility? And what can we, as persons charged with their care, do to alter this latter course?

It seems to me that there are meaningful answers to these questions—answers which apply equally appropriately to both generations (that is, to both first and second childhoods)—and that in these answers may lie at least one key to increased understanding of the diseases which challenge our interest this morning.

I say "diseases" rather than "disease," for there is indeed a disease of childhood which bears great similarity to the clinical picture of cerebral arteriosclerosis. We know it as "early infantile autism."

In both, there is frequently a related trauma which contains a mixture of the organic and the psychological. In childhood, there seems to be a much less significant organic component—at most, a congenital predisposing factor of which we shall talk later—followed by a severe psychological trauma. In the elderly, the reverse is true. Here, the predisposition is usually the result of psychological patterns of living, while the major trauma, be it acute, chronic, or a mixture of both, is organic in nature. In both of these diseases, the resultant clinical syndrome with which we, as psychiatrists, are primarily concerned is that of the psyche.

At this point, it probably would be helpful for me to briefly define these two disease entities as I will be discussing them today.

Cerebro-vascular disease, of course, results from, and produces, many kinds of physical pathology. In spite of these variations, the

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resulting psychological symptomatology is strikingly similar among them—so much so, in fact, that it is identified by one term, *organic brain syndrome.* In this syndrome, primary differences lie in the acuteness or chronicity of the process, its reversibility or irreversibility, and the degree of disturbance of cerebral functioning experienced. It is in the clinical picture of cerebral arteriosclerosis that one sees this brain syndrome in its most clearly defined and encompassing form, including defects in orientation, judgment, intellect, apperception and memory, as well as lability and often inappropriateness of affect. It is therefore to this particular disease that I shall confine my remarks, recognizing that what I shall say will also apply quite directly to the other forms of cerebro-vascular disease.

In the acute phase (when it is present), the organic and psychic factors are almost inseparably enmeshed as the ill patient fights for survival. But all too frequently, as he begins to improve physically, we see a further deterioration of his psychological functioning, until finally a reasonably healthy body may be chained to a hopelessly deteriorated mind.

There is somewhat the same pattern in *early infantile autism.* Initially, from external indications, mind and body are sound, and psyche and soma are one. Yet, in the aftermath of the severe emotional deprivation which the infant suffers, and which I shall shortly describe, the mind and the body also appear to separate, with a great part of the mind remaining frozen in infancy, while the body grows through relatively normal developmental stages. There are areas in the autistic child's motor skills which are grossly distorted, it is true, but the pathology in this disease remains primarily psychological.

Most psychiatrists believe that the definitive trauma for the autistic child occurs in the earliest three or four months of life and lies in the absence of any meaningful mothering experience. This is at a most precarious period in the child's development, one in which such an absence will block his ability to form object relationships with human beings. The infant, therefore, remains narcissistic as he grows into childhood, uninterested in the human world about him except as it serves his physical needs. Many of these children do not acquire speech, and those who are able to do so, do not seem to use language for meaningful interpersonal communication. The child thus rejects the rest of his human world, because it has no meaning or value for him.

Sub-strata of Disease

In disease, just as in health, there must first be a fertile climate in which it can develop. The strength of the defensive resources of each individual will determine to a great extent which path he will take—the one which leads to disease or to health. Certainly for both of these psychiatric illnesses, there is such a climate—one which we can identify without difficulty and which is a very considerable factor indeed during infancy and older age. The evolution of our species, which has exaggerated both the duration and the extent of the infant's dependence on others for survival, has created hazards for him which lower animals do not share. At the other end of life, there is a similar predicament. The scientific and medical advances of our era have created the same peril for our elderly, who frequently now outlive their ability to cope with this potentially endangering climate.

The elements of this climate are few in number and not very involved, and yet they have extraordinary meaningfulness for both the young and the old. They include sensory deprivation, motility impairment, and cognitive inadequacy.

The first of these, *sensory deprivation,* is probably the most important of the three. For the infant in the first two months or so of life, this deprivation is very pronounced, especially in those two senses through which he relates to his more distant environment—those of hearing and of vision. The capacity

to use both of these sensory modalities is only minimally present in early life, and the infant must first learn of his environment through those senses which involve close contact—touch and proprioception.

Similarly, the average elderly person can no longer clearly define his world through these two once most important organs. His vision in most instances has declined markedly, and his hearing is rarely acute enough to give him an accurate auditory conception of what is occurring in his surrounding world. He, too, must rely on different ways of contact with others. This of course means, as it does with the infant, that he must depend for help on people close to him, if he is to escape the confines of his increasingly constricted world. This is a dependence which, also like that of the infant, demands effort, as well as understanding and empathy, from those with whom he lives. For both ages, this constriction, if left unmodified, is extraordinarily anxiety-provoking, and for neither is the reason for this sense of disquietude obvious.

The second element in this typical climate of which we are speaking is that of *motility impairment*. For the infant, motor control has not yet been achieved—he must rely upon his mother totally for protection and for the gradual broadening of his horizons which her care will provide for him. The extent of sensory contact itself which is available to him in his early days is unquestionably to a large extent a function of the amount of maternally created motility which his mother provides for him.

How very true this is of the elderly. It is increasingly difficult for them to move about without assistance. Not only is their physical strength waning, but with this loss of adequate motility and the increasing dysfunction of other areas of their physical being, comes a sense of insecurity which is usually quite in keeping with physical reality —they are truly not safe by themselves in our world of speed and impersonality. They, as the child, need the assistance and the protection of someone who still functions well in this "outside" world. Without this, there will be little opportunity for them to remain even a small part of it.

The final element which we shall consider in this regard is that of *cognitive inadequacy*. For the very young infant, there has not yet developed a fund of memory, of knowledge, of ability to conceptualize or even to form percepts. His thinking brain is as yet new and almost completely untouched. Consciousness, as we know it, is probably absent, and his ability to respond to his environment is still almost on an instinctual level. That his cerebrum is functioning is evident—even in the first week of life, his nursing response shifts in order to better serve the fulfillment of his hunger drives. And by his second or third month, he has developed a repertoire of quite appropriate, although still primitive, responses to his environment. But in no way does his brain yet function as a thinking organ. Here, too, his helplessness requires the constant support of another if he is to survive.

The older person, on the other hand, is approaching the opposite end of this spectrum of life. His brain, although once unbelievably complex and active, has in many cases shown clear deterioration. Mental processes which once were almost automatic are now slowed, and for him to learn new tasks or to adjust to new situations is much more difficult, although still perfectly possible for the organically healthy elderly person. A fortunate few continue to be blessed with essentially unimpaired mental capacities, but for most of us, a gradual downhill process has begun. All, however, even the most intellectually agile, are in a sense walking a tightrope—one which may break or sag just when its support is most urgently needed.

There are, of course, numerous lesser areas of functioning which show similar deprivation normally in these two groups of human beings. It would seem, however, that the three we have just discussed—limitations in

sensory, in motor, and in cognitive functioning—would be sufficient to make each individual's progress through these two periods fraught with potential danger.

To this point, we have been concerned with deficits which are shared equally by those who will respond normally and those who will react with pathology when confronted with seemingly identical stresses. Often, for instance, there are several children born to one home, and yet only one of them becomes autistic. Similarly, two adults will seem to have suffered approximately the same amount and kind of brain destruction in cerebro-vascular disease, yet one regains or maintains to a large extent his former mental capacities, and the other person moves into permanent oblivion.

Again we must ask: What is it in these different persons that makes their courses so different? Or what are the differences in the external resources available to them that may be important in determining their ultimate fates? It is the answers to these questions which are meaningful to us if we are to prevent many of our patients from turning into this dead-end street.

This is not to say that the psychological symptomatology of cerebro-vascular disease can eventually be spared every victim of this illness. Not at all. No one, no matter what his strengths or those of his environment, can be protected from the physical destruction which comes with the overwhelming insult of a massive cerebral hemorrhage. Nor can even the healthiest infant, deprived, over a period of several months, of all mothering other than that minimal amount necessary to sustain life, ever develop the capacity to relate completely normally with other humans as he grows into childhood and later into adulthood. For neither can the inevitable grim consequences be altered.

Rather, I would focus on those seemingly borderline traumas, both physical and psychological—those which for some, seem to offer a challenge and to which others succumb without a struggle. What is it that will make one process reversible and yet the other so totally beyond help?

Individual Predisposition

Very important in the answer to these questions is the individual predisposition which each person carries within himself. This, of course, is beyond direct attack by the time the organic pathology has developed. But an understanding of its implications, and the ability to accurately assess and sometimes to circumvent its consequences, can be of great value in treatment.

Most psychiatrists believe that the child who will become autistic comes into the world with a strong predisposition toward this disease, congenitally unable to cope with environmental stresses which, for the normal child, would be in no way pathogenic. So it is with the elderly person. For him, it is his patterns of coping with difficulties, established throughout his life-time, which create or prevent for him this predisposition toward psychological pathology in later years. The child is born with it, but the adult, to a certain degree, creates for himself his ultimate fate. A person who has learned to take daily problems in stride, who is well-adjusted personally and is still a productive individual, is far less likely to show the pathology inherent in the chronic brain syndrome than is one who in the past was unable to cope adequately with normal life stresses, who was the constant support—and yet despair—of his physicians, or who developed neurotic patterns of behavior or still other unhealthy ways of daily adjustment. These people are just as definitely predisposed to the development of inappropriately severe psychological problems as a result of added stress in old age, as is the child who will become severely autistic in the same environment that supports his brothers and sisters without difficulty.

However, in itself, this defect—this predisposition—is not sufficiently consistent to explain the degree of illness present in either

the disturbed child or regressed adult. We must look beyond the individual to his *environment* for the other half of this puzzle which we are now attempting to solve.

Environmental Factors

Important to every human is his family. For the baby, the significant person in the family circle is his mother. It is she whom he first comes to recognize as a unique individual—different from himself and all others. At least, he is able to achieve this major step in development if his mother is a warm, sharing, and loving person who is capable of giving freely of herself in the support of his infantile needs. For the child who is to become autistic, however, his mother is more frequently than not a very disturbed person herself—one who all too commonly has not experienced adequate parenting and has remained a narcissistic, overwhelmingly needful person in her own right. Such a mother is usually quite cold—one who goes through those tasks required of her effectively but without feeling—she does it because it is expected of her, but not because she enjoys it. There is almost always resentment, a feeling of being "put-upon," and frequently, of actual dislike.

The enviroment of the elderly is also frequently pathogenic in this respect. However, responsibility for the pathology cannot always be placed directly on the shoulders of one person but must be shared by the society which has molded our family patterns. No longer are members of the extended family usually found living in fairly close geographical proximity. Rather, the older generation usually finds that as its children grow up and marry, they scatter over the country, sometimes with several thousand miles separating them from their first home. Thus, there is rarely more than one adult child available to furnish needed care to an elderly parent, with no other relative to share this responsibility with him.

Houses, too, are rarely as spacious as they were in days past, and the transplantation of an elderly relative into one of these homes far too frequently causes real discomfort. When this stress proves too much for a particular home to handle, a picture similar to the one I shall describe briefly may develop.

The harassed young mother, who often is employed outside of her home and who must also maintain this home and care for her husband and children, simply cannot spread herself thinly enough to satisfy the needs of a demanding grandmother or grandfather. The guilt which she feels at this failure easily leads to anger, to resentment of the older person simply because he is there, and finally, to an atmosphere of coldness, hostility and indifference identical in most respects to that which has much to do with producing the autistic child.

The ultimate result is frequently disastrous. Both the infant and the aged sense the rejection, equate it, consciously or subconsciously, with personal inadequacy, and finally, withdraw even more than their physical and psychological restrictions would necessitate.

The schizophrenogenic mother (and these children are considered to be schizophrenic) is identified also by a second deficit in mothering—her failure to read and then to respond to her child's non-verbal cues and demands. Or again, she may read them perfectly well, but choose not to respond.

This same deficiency is often seen where the elderly are involved. It is difficult for the older person, somewhat confused and easily upset by the smallest frustration, to always make his wishes perfectly clear. For the one who must try to understand, there is usually little extra time or energy available—certainly not enough to cope with this problem over and over again. Consequently, it is simplest to take the path of least resistance and just "not hear." Once again, the result is a further magnification of the deficits already present. For the skill involved is one of communication, which for the infant is just beginning, and for the elder-

ly, has become precariously unstable. Any skill which cannot be practiced is eventually lost, whether it be very old or very new. Consequently, the infant's development is arrested at its beginning, and the to-be-expected slow decline of the older person is turned all too frequently into a rout.

I would like to comment also on one other pathological deficiency found in the histories of our disturbed children and arteriosclerotic adults. I have already remarked on the sensory deprivation present normally for both of these generations. Unfortunately, in the development of either of these diseases, we see evidence of still further reduction of sensory stimulation in the lives of these patients. The mothers of the autistic children seem unwilling or unable, perhaps, to provide even minimal amounts of sensory stimulation in any area. They are all too likely to seize upon the quietness of the passive infant as an excuse for not picking him up--"He never wanted me to"—or to wheel the baby out into the yard to stay alone for hours where "he is happiest." Thus the mother, at the very time when her child is most needful, is simply non-available.

Again, there is a corollary here with the elderly. How many times, I wonder, has the daughter or daughter-in-law suggested to her mother that she might like to take a nap—or perhaps to sit on the front porch—when the message she was actually conveying was that she couldn't be bothered with walking around her or trying to carry on a conversation when she had so many other things on her mind. And usually, this is a pattern of behavior common to the other members of the family—the older person is, realistically, in the way. So more and more, then, the older person must be isolated if the family itself is to survive.

How infinitely more disturbing this sensory deprivation becomes, in most cases. when hospitalization is necessary. Not only does the actual illness decrease the patient's coping ability, but the very circumstances of his environment seem to mitigate against him. Sound is hushed, lights are dimmed. There is little of color or brightness in most hospital rooms. Even more pathogenically, contact with other humanity is further reduced. There are visting hours to be observed, and even if these are relaxed, there are all too few of these patients whose relatives can spare enough time to stay with them. If visitors do come, it is usually during the day when the sensory stimulation from the outdoors is at its highest intensity. It is when night comes that our older patient suffers the most deprivation. Now all is truly quiet, activity is stilled, and there is little of the sensory stimulation which is so necessary if he is to maintain his orientation and, indeed, his contact with reality. The monotonous hiss of oxygen or the hum of various bedside instruments further serve to reduce all stimulation to one pervasive and deadly level. Monotony is indeed the key-word.

The case against prolonged hospitalization is equally forceful for the infant. The crippling—in fact, killing—effect of lengthy hospitalization on the infant was described so effectively and dramatically by Rene Spitz several years ago that today very few hospitals allow an infant to remain institutionalized for long periods unless absolutely necessary for his physical integrity, and then they make quite stringent efforts to see to it that the mother or some other close relative is present most of the time, and, in some cases, actually sleeps in.

The Clinical Picture

The clinical picture which comes as a result of all or a portion of these factors, is so identical in these two age groups that it can be described with the same phrases, with no loss of meaningfulness.

First, *there is a pathological need for sameness.* Neither age tolerates changes when these illnesses are present. Both the autistic child and the arteriosclerotic adult resist changes either geographical in nature or in the persons who are around them. This is

not because there is any real affective investment in either—this is almost frighteningly absent in most cases—but rather because change is threatening to their precariously held sense of security. An autistic child whose family must move from one house to another objects frantically as he sees his bedroom furniture being removed to the moving van. It is not until he sees it reassembled in as nearly as possible identical positions in his new home that he is able to relax and accept the change.

The same is true of the elderly. There are many older persons living alone in the home which they shared with their husband or wife who absolutely refuse to leave that home, even when the new one offered to them would give companionship which they now lack, and much greater comfort than does the "homeplace."

Second, *there is withdrawal into their "own little world."* The child literally does not make contact with humans, although he may do so quite easily with toys. In turn, the arteriosclerotic adult may recognize a once deeply loved child by name, but here too the emotion is now shallow. There are for him no real affective ties with the present. He lives so frequently in the period which he remembers with the greatest happiness—when he was young and "alive." His "young" family comes once again to join him, and he has no interest in, or desire for, the present. Both ages have abandoned the present life in favor of one which they seem to remember as better.

Closely allied to this is *the partial to complete loss of contact with reality.* For the autistic child, this is frequently accomplished almost self-hypnotically: through masturbation; through twirling a "twiddler" in front of his eyes throughout most of his waking hours; or through bodily whirling around and around for seemingly endless periods of time. All of these techniques effectively shut the child away from his reality, and he must almost forcibly be brought back. He responds in his way when it pleases him to do so, but always it seems as if he is not really aware of reality as it is to others.

For the elderly, this partial withdrawal from reality is even more evident. For they can live in two worlds, the real and the unreal, simultaneously and seemingly without difficulty. Although they recognize members of their families and friends, and call them by name, they at the same time converse with them about others, long since dead, as if they had recently been in the home, and as if they were expecting them back momentarily. For them, if the process has been present for even a few days, this mixed awareness of reality is usually an unchanging part of their existence for the rest of their days.

Fourth, *both show narcissism* in marked degree. For them, the world should exist for the satisfaction of their increasing needs—and for them alone. The fact that it cannot at times is meaningless to them and only reinforces their belief that another age was better and should be returned to, if at all possible.

Fifth, *both frequently have the appearance of mental retardation.* For neither one, in the early stages of disease, is this necessarily more than an illusion. The child has his intellectual potential for the future yet untouched, and for the adult, much remains of his mature abilities if he can only be helped to maintain a grip on them. But sadly for both, the reversibility of this pseudo-retardation depends to a large extent on the immediacy of help. After a period of time, variable in length, the *apparent* mental retardation becomes *real*, and then there is no hope of recovering that which has been lost.

Disturbances of affect are characteristic of both. The autistic child is noted for his truly horrendous temper tantrums in the face of frustration or the removal of a favorite toy. Very frequently, too, one of the characteristics which make living with the elderly at times so difficult, the unpredictability of their emotional climate, may make life impossible for the entire family. For with the elderly, the least change may be upsetting

and result in childish episodes of sulking or of temper displays which seem even more difficult to tolerate than do those of the disturbed children.

A final deficit which we see in both groups is their *impairment of judgment.* For instance, an autistic child cannot be left without supervision for a moment. An almost universal trait is their ability to slip away, even from watchful eyes—a trait which is most dangerous since these children have no fear or ability to judge danger. They are truly impulse-driven, and that which drives them seems to have no meaning for the normal person. In all other areas of behavior, too, we find similar lacks of any significant ability to judge their actions as other children do.

The ability to consider the consequences of acts or of words is also one which in the elderly is notable primarily by its absence. Their behavior and sometimes their verbal communications are frequently a source of embarrassment to their families. For them, there no longer seems to be any ability to judge appropriateness or lack of it in their activities. Danger is also present for them, but its source is different from that of the autistic child. They do indeed feel fear, but for them, impaired judgment of danger and slowness of reactions may make the fear meaningless and impotent by the time it appears.

Treatment

Therapy for the child is always tortuous, long and difficult, and to date, it has had dreadfully little success, no matter in what form it has been attempted. However, at University Hospital, as at other children's psychiatric services over the country, we are beginning to achieve limited degrees of success with the four or five autistic children whom we are able to treat on our service at any one time. Our therapeutic aim is to give them an experience in positive human relationship and in associated sensory stimulation which will as nearly as possible proximate the mothering which they missed in infancy. This, we hope, will help them to develop as much as possible of the ego integrity which they should have acquired normally in their first year of life (our autistic children have ranged from three to eight years of age at the time of their admissions). We have recently been able to establish a treatment pattern in which each of these children is assigned to the exclusive care of a woman chosen because of her ability to relate warmly and empathically with very young children. This relationship is maintained for approximately six hours daily five days each week. During the morning hours, they attend a very flexible and simply structured kindergarten class in which we also attempt to give them experience in group activities as well as help in achieving some success experience in the world they have shut out. Any such success, even the most infinitesimal, is instantly rewarded. This program is beginning to show some definite results—all but one of these children who were mute or echolaliac are now beginning to make some efforts to use speech meaningfully, even if still very limitedly. Even more importantly, they all have begun to show definite ability to relate both positively and negatively to those about them and to differentiate between different persons in the ways in which they relate to them. Grantedly, none of our initially nonverbal autistic children will be ever truly normal persons, so far as present predictions can determine, but some of them, at least, should become productive, if somewhat "odd" adults.

Treatment for the elderly is equally demanding and is based on similar techniques and philosophies to those already described. However, our goals must be different—for the elderly, the preservation of that which is still undamaged, whereas for the child, we are concerned with stimulating the growth of those non-developed ego functions which were frozen in early infancy. Fortunately, there is much which can be done in our efforts to tip the scales toward health for our elderly patients. The form of treatment

which seems to have particular effectiveness is also almost entirely environmental. Since environment, as it is most meaningful to us with this group of patients, involves either a hospital room or a converted sick room at home, it is to these areas that I will direct my comments.

First of all, I think it imperative that hospitalization of the elderly should be limited to those conditions for which adequate care is available only in a hospital. All too frequently in these days of Medicare and extended hospital insurance, when hospitalization no longer imposes a financial strain on the family, it is sought as a matter of convenience. If an adequate room is available in the patient's own familiar surroundings and if his physical condition does not require more skilled and technical support than can be made available in his home, then he should certainly remain there. There is no doubt whatever that in his own familiar surroundings, the elderly person is much more likely to maintain psychological stability than he can do in the hospital.

But if hospitalization does become essential, all is still not lost. In case of major, acute illness, as in every other area of life-endangering disease, psychological treatment must take a back seat to the medical or surgical therapy. But as soon as it is possible to do so, the psychological aspects should be given cognizance. I firmly believe that brightness, color and light are of major importance. There should be sensory stimulation within the limits which can be tolerated. A radio, television, the voices of a friend or two around his bedside, even when he cannot yet join them—all are of help in maintaining an uncertain hold on reality.

People—empathic, giving people—should be near, available to him whenever he needs or wishes for company. They should be ready to respond to his needs totally—to sit quietly with him when he is tired, or to talk with him when he craves contact. Especially is this important in the delirium which almost inevitably follows surgery, trauma, or almost any major illness which occurs in this age group. Here it is that the quality of the companionship is what makes the difference. This kind of care is exceptionally difficult to provide, for it requires total dedication, at least during the period of the delirium. The attendant, whether she is nurse or relative, has one task from the psychological point of view—she must maintain the patient's hold on, and desire for, reality. This necessitates frequent repetitious descriptions of reality as it is at that moment—detailed descriptions of the room, the hall outside, the general picture of the hospital, as well as reminders of the patient's own identity from time to time—anything which will make the present meaningful to him. There must also be correction of misperception—here, adequate lighting is important. It is not difficult in most instances to accomplish this—a disturbing shadow may be obliterated by an added light or by an unhurried sympathetic explanation. If this approach is to be effective, it must be maintained as long as the patient is awake and misperception is present. During the daytime, delirium is less likely to be present, but at nighttime, hallucinations, regressions to the past, misinterpretation of the present—all may go on from dusk to dawn. It is at this time that isolation and loneliness must be avoided at all costs. Even one night of uncontrolled regression into the days of youth may present such a siren picture of warmth and happiness that the patient will not be able to give it up and return to the pain and unattractiveness of a bleak hospital room.

As soon as possible, there should be some mental and physical activity—reading, handwork, visits to areas beyond the confines of his hospital room, anything within his capacities which requires his active participation. This is of marked value to the patient for it gives him not only some needed variety in his daily routine but also a sense of accomplishment. With the elderly, for whom so many things are impossible, this is a not inconsiderable reward.

Some day I hope that all hospital rooms

will be designed primarily for their sensory effects on the patients who occupy them rather than for the ease and convenience of the housekeeping staff. Bright draperies, pictures on the walls, music (as well as oxygen) piped into each room—when these are present and are supplemented by small personally meaningful objects from home, the hospital room in itself may not only offer nothing of psychological trauma for the patient but may indeed actually offer therapeutic dividends for him.

What I have recommended to you is admittedly the ideal. However, if those who are responsible for maintaining the psychological intactness of the aged can first remain aware of the significance which lies behind each symptom they see, and then try, not only to correct, but actually anticipate every possible psychological problem, I believe the number of beds in geriatric hospitals occupied by senile and vegetative bodies simply waiting for death's release could be almost infinitely reduced.

Ultimately of course, the extent to which recovery can be achieved depends on three factors:

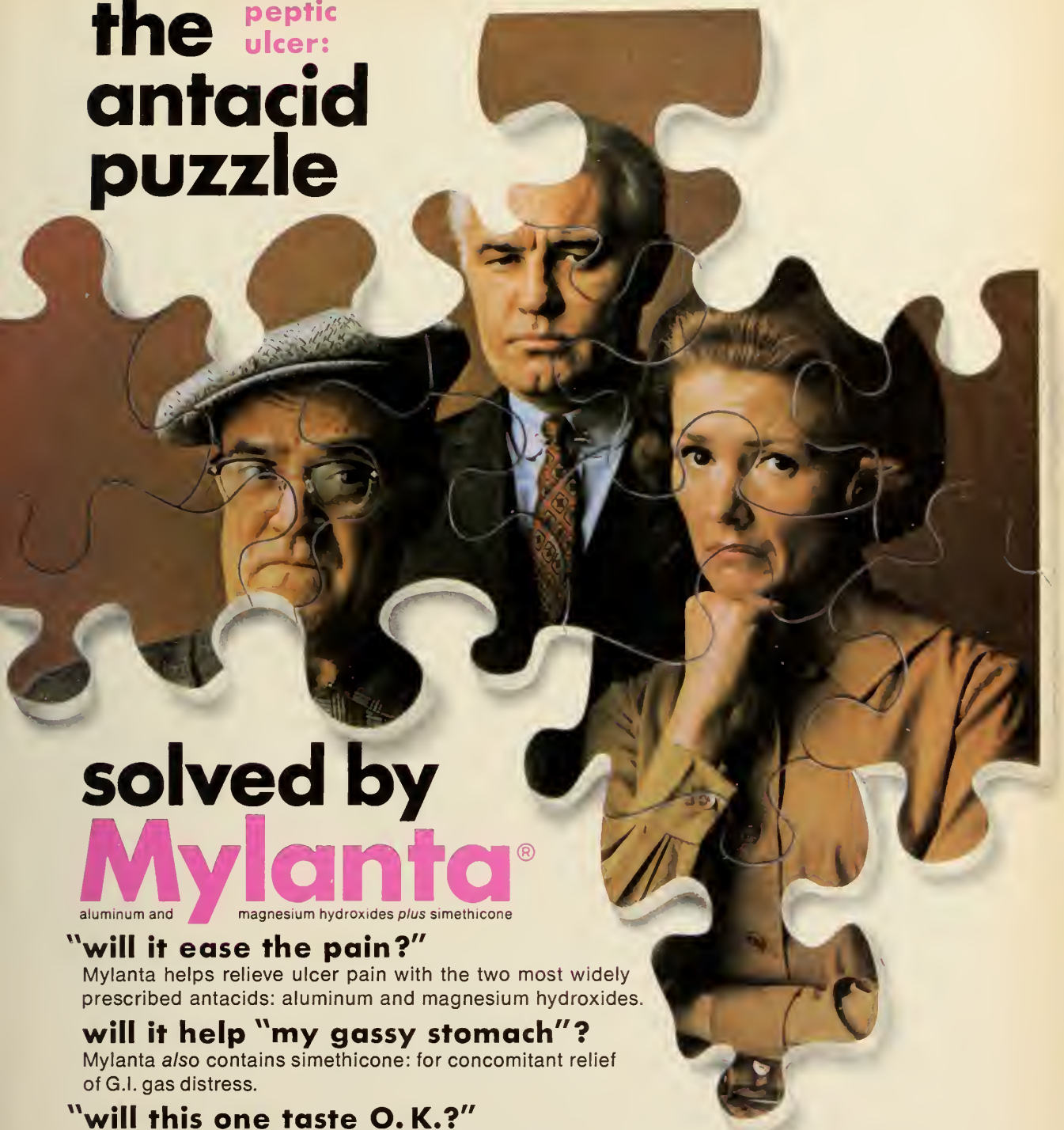
1. The severity of the illness,
2. The extent of the predisposition of the patient toward pathology, and
3. The real dedication and strength of the environmental support which is available to him.

Summary

In summary, I have attempted to relate two illnesses, cerebral arteriosclerosis in the elderly and early infantile autism in the young.

They have been discussed from the standpoint first of normal sub-strata, common to the weak and to the strong, on which they may develop. Secondly, the roles of individual predisposition to illness and of pathogenic environmental factors in the etiology of psychological illnesses in these two age groups were discussed. Clinical pictures of both were presented, and in the concluding portion of the paper, a therapeutic approach thought to be most potentially helpful for each age was summarized.

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Warnings—Watch for the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism, retinal thrombosis); if present or suspected discontinue the drug immediately.

British studies reported in April 1968[1,2] estimate there is a seven- to tenfold increase in mortality and morbidity due to thromboembolic diseases in women taking oral contraceptives. In these controlled retrospective studies, involving 36 reported deaths and 58 hospitalizations due to "idiopathic" thromboembolism, statistical evaluation indicated that the differences observed between users and non-users were highly significant. The conclusions reached in the studies are summarized in the table below:

Comparison of Mortality and Hospitalization Rates Due to Thromboembolic Disease in Users and Non-Users of Oral Contraceptives in Britain.

Category	Mortality Rates		Hospitalization Rates (Morbidity)
	Age 20-34	Age 35-44	Age 20-44
Users of Oral Contraceptives	1.5/100,000	3.9/100,000	47/100,000
Non-Users	0.2/100,000	0.5/100,000	5/100,000

No comparable studies are yet available in the United States. The British data, especially as they indicate the magnitude of the increased risk to the individual patient, cannot be applied directly to women in other countries in which the incidences of spontaneously occurring thromboembolic disease may differ.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or sudden onset of proptosis, diplopia or migraine. Withdraw medication if papilledema or retinal vascular lesions are found.

Since the safety of Ovulen in pregnancy has not been demonstrated, it is recommended that pregnancy be ruled out for any patient who has missed two consecutive periods before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the first missed period.

A small fraction of the hormone agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions—Pretreatment physical examination should include special reference to the breasts and pelvic organs, and a Papanicolaou smear.

Endocrine and possibly liver function tests may be affected by Ovulen. Therefore, it is recommended that such tests if abnormal be repeated after the drug has been withdrawn for two months.

Pre-existing uterine fibromyomas may increase in size under the influence of progestogen-estrogen preparations.

Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation.

In breakthrough bleeding, and all irregular vaginal bleeding, consider nonfunctional causes. Adequate diagnostic measures are indicated in undiagnosed vaginal bleeding.

Carefully observe patients with a history of psychic depression and discontinue the drug if severe depression recurs.

Any possible influence of prolonged Ovulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study.

A decrease in glucose tolerance has occurred in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be observed carefully while receiving Ovulen.

Because of the effects of estrogens on epiphyseal closure Ovulen should be used judiciously in young patients in whom bone growth is not complete.

The age of the patient constitutes no absolute limiting factor, although Ovulen therapy may mask the onset of the climacteric.

The pathologist should be informed of Ovulen therapy when relevant specimens are submitted.

Adverse Reactions—A statistically significant association has been shown between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: cerebrovascular accidents, neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement, secretion), change in weight, changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, allergic rash, rise in blood pressure in susceptible individuals, mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme and nodosum, hemorrhagic eruption, itching.

The following laboratory results may be altered by oral contraceptives: hepatic function: increased sulfobromophthalein and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T^3 uptake values; metyrapone test; pregnanediol determination.

References: 1. Inman, W. H. W., and Vessey, M. P.: Brit. Med. J. 2:193-199 (April 27) 1968. 2. Vessey, M. P., and Doll, R.: Brit. Med. J. 2:199-205 (April 27) 1968.

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1968 Report On Tuberculosis Control Program

An Abstract

BY DR. FREDERICK S. WOLF

Director, Division of Tuberculosis Control

State Health Department

This presentation is designed to bring to the attention of this Board the present status of the Tuberculosis Control Program and its objectives as well as a discussion of the tuberculosis hospitals. The tuberculosis control program is presently divided into two parts: That which is specifically designed to find cases, to find contacts, to assure chemoprophylaxis and to maintain surveillance of case finding, case holding, and prevention; and, second, hospital care.

Historically there have been two means of describing the morbidity of a specific disease, the incidence of new cases and the number of deaths resulting from that specific disease. Reviewing the situation for Alabama the number of deaths from tuberculosis has been in a very modest decline over the past several years and has recently reached the level of 226 for the entire year. This is still substantially above the national average but today there is not quite as much credence put on death rates as there was many years ago.

The new active case graph differs considerably from the graph of tuberculosis deaths. We have over the past years achieved a sort of plateau with little peaks and valleys. This is not an unusual picture because we are now reading annual reports from other states with a tuberculosis problem reporting much the same picture.

For the out-patient program the state has been divided into seven separate control districts. These districts do not include Jefferson County which has its own Federal Grant, a grant which expires June 30, 1969. This leads to a certain amount of confusion in the presentation of statistical data. Suffice it to say that our seven districts plus Jefferson supply a program to 90 per cent of the known cases of tuberculosis.

In this particular program the word "open" is used in a somewhat different form from that which we are accustomed. By this definition "open" implies a case which is

maintained under surveillance for a five year period dating from the date when first considered arrested. In these districts regularly scheduled chest clinics are held. Fortuitously there are two physicians assigned us by the Public Health Service. One working in the Gadsden District and the second working in the Mobile District. Through the efforts of the executive secretary of the Wire Grass Chapter of the National Tuberculosis Association we met with the Medical Societies of the counties in this area. As a result of these meetings each county medical society agreed to furnish a physician to provide the clinical support for the tuberculosis clinics to be held in his particular county.

The progress of the out-patient control program, as we have equaled or exceeded all evaluation standards set by the 1959 Ad Hoc Committee. We have been told by the communicable disease center personnel that our rate of placing contacts on prophylaxis is the highest by far of any community in the United States.

This approach has led by evolution into the so called child centered program. Intensive tuberculin testing of children provides an opportunity for early chemoprophylaxis or even chemotherapy. The child centered program not only locates the very early invasion of the human by the tubercle bacillus but provides a contact group for investigation. It is this group which, of course, we are particularly concerned with protecting. In dealing with the children we find ourselves in conflict with the attitude of the practicing physician. Forty years ago the picture of tuberculosis was one of acute youthful disease and its complications as well as the involvement of the adult. Today the incidence of childhood tuberculosis is apparently restricted to what is defined as the Ghon complex: Primary pulmonary lesion with involvement of the draining lymphatics for that area of the lung. Pediatricians do not consider this a serious disease because the children do not die when infected at this level of intensity. For this reason we find children attending school treated by private physicians without medication knowing full well that the initial lesion will heal. A death will not occur and they will not contribute to the mortality statistics. These youngsters, of course, are a concern to us because the very equivocal literature will not tell you whether or not these children are putting into circulation a virulent tubercle bacillus and until sufficient study has been done to determine this we are groping in the dark. It is possible to cite an incidence of such involvement. Most recently an 11 year old girl with such complex was permitted to attend a local Jr. High School with frank uncalcified, in other words a reasonably active Ghon complex, and low and behold did show in the opposite lung some very fuzzy material which indicated a tuberculous involvement of the opposite lung. The child was put on chemotherapy, some would call it chemoprophylaxis because they do not believe or accept that this is in fact active tuberculosis.

As a result of our work with the Child Centered Program we came to the conclusion about a year ago that the incidence of new active cases was not an effective index for the guidance of our tuberculosis control program. For this reason then we developed and published a form which is capable of computer digestion to provide us the detailed data on the tuberculin reactors. It is accepted that only the individual with a tuberculin positive test will at some point in time be at risk to the development of frank active tuberculosis. We have thus far had placed into the machine some 30,000 of tuberculin tests covering all age groups. We will be able to present to each county health officer the actual incidence or prevalence of tuberculosis in his county. Over all the number of reactors is running close to 5.6 per cent. In the adult group the reactor rate is between 14 and 15 per cent. We do not believe that we will have a statistically valid picture until we have achieved in the range of 250,000 tests.

It is our intention to do such studies on an annual basis and thus determine the pro-

gress of the incidence or prevalence of the disease over a period of years . . .

We are not content to do tuberculin testing. We endeavor on every testing occasion to obtain a 14 x 17 plate the same day that the tuberculin test is read as positive, that is 10 mm or over. We work on the assumption that any child of 12 or younger is a relatively recent converter and therefore chemoprophylaxis or chemotherapy is in order. . .

The operation of quality out-patient clinics is a key function in this phase of the tuberculosis control program. By quality clinic we require the presence of a clinician with an interest in diseases of the chest, a public health nurse, X-ray technician, clerk and field investigators who have been most effective in ferreting out and persuading the semi-recalcitrant patients to make his appearance at the clinic for sputum testing, X-ray and refill of his prescription. . . . The principal problem in the establishment of these chest clinics is the finding or recruiting of a physician who is willing to give of his time and knowledge for the very modest honorarium available through the project. At the present time this honorarium is $10.00 per hour plus $1.00 for each patient actually seen.

One of our more aggressive physicians has placed into operation in his area a program of re-call of the so called inactive case, that is the individual who has been removed from the open file after five years so that a portion of his work involves reviewing the individuals who have not been seen by a physician in as many as 15 or 20 years. Unfortunately we are finding in these people positive sputa and evidence of continuing chest disease. This should be expected because there has been recorded an annual breakdown of those individuals not treated by chemotherapy in the range of 4 per cent per year.

Dollars in support of this program are provided by Federal Grant which expires both for the state and for Jefferson County on June 30, 1969. There is no provision for the continuance of this program under state funds. Unless we are fortunate enough to produce figures and evidence of the success of our program we shall have a rather difficult time in competing for comprehensive medical funds. The reality of this is that tuberculosis does not have heart appeal. It can not present a sense of drama and sorrow in its solicitation of funds. The individual with active tuberculosis usually looks pretty healthy. In our state and in fact throughout the literature he would be expected to be a male and approaching the prime of life. This unfortunately is not so. Our figures show that about 30 per cent of our people with tuberculosis are in the 65 or over bracket.

There are now seven medical facilities operating 1125 licensed beds for the tuberculous individual. Of these one is accredited, the remainder according to the Bureau of Licensure and Certification are not in compliance with existing regulations. Deviations, we are told, vary from installation to installation.

The national and state decline of patient census in hospitals date from introduction of streptomycin immeasurably aided by the additional chemotherapeutic drugs presented to the medical profession. The reasons for the reduction are three fold. 1. The introduction of chemotherapy. 2. The establishment of quality out-patient clinics and 3. The tendency of some physicians to attempt and I repeat this—to attempt to treat tuberculosis in a household situation.

The definition of a quality out-patient clinic has already been given and it is because of this that in three of our hospitals selected patients are being discharged more rapidly than the precepts laid down by the National Tuberculosis Association in coordination with HEW. This is done on a selected basis where in the judgment of the medical director, the individual selected for early discharge has proven himself to be a dependable character cooperative in taking medication and comply-

(Continued on Page 546)



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BLUE CROSS-BLUE SHIELD OF ALABAMA ®

(Continued from Page 544)

ing with hospital regulation, in the way he has accumulated knowledge of his disease and his acceptance—and this is important—his acceptance of the fact that he did in fact have tuberculosis and could be anticipated to be followed regularly in the out-patient clinics.

My statement on the fallacious treatment of patients at home by private physicians or by clinics was deliberate. Admittedly there is a rather vociferous group in the medical literature in support of the use of chemotherapy in an out-patient situation for active infection. In doing this we as physicians are violating the basic precepts for the control of infectious disease because these individuals, are putting into aerosol form viable tubercle bacilli fully capable of continuing the disease process in others. We have those who say that the organism is no longer infectious after a week of chemotherapy. There are some who say the organism is no longer infectious and capable of infection after three days of chemotherapy. We have not found it so. Our laboratory, which is the largest tuberculosis laboratory in the country, is finding organisms capable of growth, capable of disease production seven months after culture material was obtained from the patient under treatment. Drug resistant organisms are reported.

An additional loss to the program is the failure to educate these people under treatment by private physicians in the home situation to such simple processes as protecting others when sneezing, coughing, expectorating, singing, shouting, or cheering. It is in these situations that the greatest amount of aerosol is produced and distributed to friends, colleagues and family. There is no knowledge given to these people, no training on what tuberculosis is and what the requirements are for the individual to exist through a normal life time.

The average "hospitalization" period in our sanatoria is slowly falling. The present level is an average of 191 days with a median of 130 days. During this time care is provided by the available staff under the active direction of the medical director/superintendent. The quality of this care varies from facility to facility dependent upon the training and interest of the medical director. On the average this achieves a good level of medical care. The medical directors include two Board Internists (Batson and Gadsden) two general practitioners (Jefferson & Montgomery) and three physicians with long term experience in pulmonary diseases (Decatur, Tuscaloosa and Mobile).

Intensive effort has been made to recruit physicians for our TB Control/Hospital program. Sixteen responses to a blind advertisement resulted in two interviews. Both of the physicians declined the appointments. A second recent blind advertisement has brought three replies. None have answered our follow-up letter. The older medical director/superintendent type is fast disappearing. The younger men with an interest in chest disease desire a continuing program of diagnostic clinic—hospital—case holding and surveillance. And the opportunity to do productive research.

Each santatorium was located based upon new active cases reported from that section of the state and selected to make them easily accessible to the greatest number of people with a minimal effort. It is desirable to keep a man or a woman who is going to be hospitalized for a long period within reasonable distance of his family.

Each of the institutions has been made fully aware of the desire of this board that they achieve accreditation. This has not been an easy matter to sell to the local boards of trustees. The reason is quite simple. As of today only two of our sanatoria are in reasonably solvent condition because of the sale of portions of their real estate or because of accumulation accruing from contributions and insurance collections over prior years. The other sanatoria have minimal funds, in fact on occasion these borrow from local

commercial banks to finance their current pay-rolls.

Information copies of budgets submitted to our office indicate that there will be still further increase in costs during the fiscal year 1 Oct. 68 to 30 Sept. 69. In large part this increase in cost is a result of the effects of the minimum wage and hour law requiring an increase in the hourly rates of pay and a reduction of the number of hours worked without payment of over-time. This increase in cost will be over a hundred thousand dollars. Drug detail men project an increased cost of tuberculosis drugs during the coming months. We are all aware of the increase of other cost items.

Each institution has been approved for payments under part B of Title 18. What these will amount to is not presently known. Every effort is made by the hospital administrators to collect insurance that may be available to them and to accept and solicit donations to assist them. In addition all hospitals are billing the county commissioners or boards of revenue for the difference between the subsidy received by the state and the actual cost per day per patient. Despite the collections from counties, charitable organizations and insurance a deficit cash flow exists so that those hospitals with a small sum in the bank are eroding this reserve while those without such reserve approach insolvency.

Of interest, is the fact that we are attempting to practice in our sanatoria good general medicine. With about 30 per cent of our hospital population, 65 years of age or over, the Medical Director is faced with problems in general medicine, the diabetic, carcinoma, diverticulosis, and the hypertensive. Other pulmonary disease than tuberculosis is not only diagnosed but is treated within these facilities. This is in keeping with the requirements of the Basic Law. We recommend that the quality of medical care provided in our sanatoria be improved by the addition of a rehabilitation program: by increased depth of laboratory support including respiratory problems other than tuberculosis, by psychiatric support and by a social service section.

Greatest concern to us all is the dollar cost of sanatorium operation. The figures presented by the several institutions are subject to audit and some are audited by more than one organization. The hospitals where they have the funds employ their own certified public accountants. Others make direct appeal to the Examiners of Public Accounts because then there is no charge for such analysis. An accredited hospital must be audited by an agent of the third party insurer. The third party insurer through the auditing firm of Ernst and Ernst confirm the cost figures at Gadsden, our only accredited hospital, resulting in an additional payment of some 4,000 dollars to this hospital.

We have in our possession the budget presented and approved by the states of Florida,

(Continued on Page 548)

Tuberculosis? Influenza?
Pneumonia? Leukemia?
Hodgkin's Disease? Syphilis?
Systemic Fungal Diseases?
Chronic Chest Diseases?
or
HISTO?
(Histoplasmosis—"The Masquerader")



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HISTOPLASMIN, TINE TEST
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(Continued from Page 547)

Louisiana, Mississippi, and Georgia. There are some slight variances in accounting procedures here which make it a little difficult for me to develop a comparative spread sheet but they have been given to trained personnel for analysis. The median point for payment seems to be about $20 per patient day.

Fiscal data for 1967 and eleven months of fiscal year 1968 are included in this report. Our sanatoria are affected with the same illness that all patient care facilities are reporting to the general public, that is the squeeze of rising operating cost. These costs now on average have reached the level of 10.58 dollars per patient day.

Noting the apparently steady decline in the sanatorium patient census a confidential report was prepared and presented to Dr. Myers covering a five year program for the inactivation of our tuberculosis treatment facilities. This provided for the closure of one institution in the 1969-70 period and one in the period 1972-1975 reducing our licensed beds by 384.

No firm date for the disestablishment or reduction in licensed bed availability for two other sanatoria undergoing extensive rehabilitation was made. These institutions contain 219 licensed beds. We need to complete our study of the prevalence of tuberculosis in the area these units support. The units remaining in the program will contain 530 licensed beds providing 193,450 patient days. Projections suggest that this required level of institutional care will be reached in 1983-1985.

In retrospect this decline in patient census was underway prior to the payment of the state subsidy on a licensed bed day rather than a patient day basis.

Americans Turning To Physicians For Sex Counseling

Americans—especially teenagers and wives—are turning to their physicians for sexual counseling far more frequently now than they did five years ago, a newly-completed national survey has found.

The survey was reported in the second issue of Ortho Panel published by the Ortho Pharmaceutical Corporation of Raritan, N. J. The questionnaires are mailed to 5,000 physicians (general practitioners and obstetricians-gynecologists). The current survey's 31.9% response indicates the American doctor's high degree of interest in sexual counseling.

A heavy majority (63%) of the 1,595 physicians answering the latest Ortho Panel questionnaire believe that their patients' sexual maladjustments are most often caused by psychological problems.

A breakdown of the results shows that the younger physician is more likely to attribute sexual problems to emotions than is the older physician, who tends to blame ignorance.

Among sexual problems the surveyed doctors said they treat frequently are sexual dissatisfaction, frigidity, impotence, and homosexuality. Compared to their experience five years ago, these doctors see patients with homosexual problems with about the same frequency as they did five years ago. Frigidity is a sexual problem seen with just a bit more frequency.

Impotence is apparently an increasing problem. So is sexual dissatisfaction. Also more frequently seen by physicians now than five years ago are teenagers with sexual problems.

A once-popular treatment for back pains was to have the seventh son of a seventh son stand or walk on the patient's back.





The pain of earache was allegedly relieved by holding a hot roasted onion to the ear.

For headache, a sovereign remedy was to wear a snakeskin round one's head.



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Louie lost weeks with acute shoulder bursitis. That's a lo
of pain, stiffness and tenderness...and also a lot of fish
It might have been different with **Butazolidin® alka**

100 mg. phenylbutazone
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If it doesn't work in a week, forget

But please don't forget this:

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently. Large doses of the alka formulation are contraindicated in glaucoma.

Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Persistent or severe dyspepsia may indicate peptic ulcer; perform upper gastrointestinal x-ray diagnostic tests if drug is continued. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with caution in the first trimester of pregnancy and in patients with thyroid disease.

Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. Patients should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage occur. Make complete blood counts at weekly intervals during early therapy and at 2-week intervals thereafter. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The more common are nausea and edema. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately before or after meals or with milk to minimize gastric upset. Drug rash occasionally occurs. If it does, promptly discontinue the drug. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), or a generalized allergic reaction similar to serum sickness may occur and require permanent withdrawal of medication. Agranulocytosis can occur suddenly in spite of regular, repeated normal white counts. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity angiitis, pericarditis and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.



Dosage in Painful Shoulder: Initial: 3 to 6 capsules daily in 3 or 4 equal doses. Trial period: 1 week. Maintenance dosage should not exceed 4 capsules daily; response is often achieved with 1 or 2 capsules daily.

In selecting the appropriate dosage in any specific case, consideration should be given to the patient's weight, general health, age and any other factors influencing drug response.

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Butazolidin® alka Geigy

Capsules
100 mg. phenylbutazone
100 mg. dried aluminum hydroxide gel
150 mg. magnesium trisilicate

BU-6210

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your patient can feel better while he's getting better

Achrocidin®

Tetracycline HCl—Antihistamine—Analgesic Compound

Each tablet contains: ACHROMYCIN® Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Caffeine 30 mg.; Salicylamide 150 mg.; Chlorothen citrate 25 mg.

In tetracycline-sensitive bacterial infection complicating respiratory allergy, ACHROCIDIN brings the treatment together in a single prescription—prompt relief of headache and congestion together with effective control of the organisms frequently responsible for complications leading to prolonged disability in the susceptible patient.

For children and elderly patients you may prefer caffeine-free ACHROCIDIN Syrup. Each 5 cc contains: ACHROMYCIN (Tetracycline) equivalent to Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Salicylamide 150 mg.; Ascorbic Acid (C) 25 mg.; Pyrilamine Maleate 15 mg.

Contraindications: Hypersensitivity to any component.

Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.

Precautions: Drowsiness, anorexia, slight gastric distress can occur. In excessive drowsiness, consider longer dosage intervals. Persons on full dosage should not operate vehicles. Nonsusceptible organisms may overgrow; treat superinfection appropriately. Treat beta-hemolytic streptococcal infections at least 10 days to help prevent rheumatic fever or acute glomerulonephritis. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity* reactions—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

Upon adverse reaction, stop medication and treat appropriately.

Lederle

350-B

RESTRICTIVE COVENANTS—AN ALABAMA DECISION

An addition to the JOURNAL begins with the inclusion of this article on one of the legal aspects of the practice of medicine. Each month in the future an article of legal interest to the physician will be prepared by Reginald T. Hamner, Director of Legal-Legislative Affairs, of MASA.

Restrictive covenants—agreements not to compete—are fairly common in three types of contracts involving physicians: (1) employment contracts, (2) partnership contracts, and (3) contracts for the sale of a medical practice.

Agreements in physicians' contracts not to compete with one another in the practice of medicine within a particular area are valid in most states if the restrictions set forth are reasonable in view of all the circumstances of the particular case.

Traditionally, the criteria of reasonableness of covenants not to compete have been the duration of the agreement and the area it covers. In addition to the above considerations, another test by which the courts judge the reasonableness of all restrictive covenants is whether the enforcement of the covenant would be injurious to the public interest. It was the consideration of this last measure of reasonableness which resulted in an Alabama Court's refusal to enforce such a covenant recently.

In this decision[1] involving two physicians, the Supreme Court of Alabama was called upon to decide the validity of an agreement which sought to restrict one physician from engaging in the practice of otolaryngology within a 50 mile radius of his former colleague. One of the physicians enjoyed an established practice in the area. After an exchange of letters, the physicians entered into an agreement from which an "association" was established. The agreement contained a provision that the incoming physician was to receive a straight salary for a period of 12 months. At the end of this time, his productivity was to be evaluated and his remuneration for the succeeding six months was to be a percentage of his gross production during the first 12 months, as applied to the net income. Either party had the right to terminate the agreement by giving the other a one month notice of his intention to terminate. The agreement further contained a provision that, should termination occur, the incoming physician would not practice his specialty of otolaryngology within a radius of 50 miles of his former associate. The stated purpose of this provision, according to the established physician, was the protection of his practice in light of the fact that the incoming physician would be exposed to the whole weight of the established physician's practice; and therefore, damage to that practice would result if the incoming physician practiced within a 50 mile radius after termination of the "association."

Dissatisfaction with the keeping of the records during the association resulted in the incoming physician giving notice of his intention to terminate the agreement. He further declared his intention to join the staff of a clinic in the same city.

The established physician, as complainant, then brought suit in the Circuit Court to prevent the incoming physician, the respondent in the lawsuit, from engaging in the practice of otolaryngology within the 50 mile radius set forth in the agreement. The suit was dismissed and the complainant appealed. The following discussion of the opinion of the

(Continued on Page 557)

1. Odess V. Taylor, Ala., 211 So 2d 805 (1968).


Knee-deep

in osteoarthritic pain

If aspirin doesn't help, move in with Tandearil.

The trial period is brief: 1 week. Try one tablet q.i.d. at first. Tandearil usually starts working within 3 to 4 days. When response occurs, as little as 1 or 2 tablets daily may hold back pain and stiffness, and increase joint motion.

On the next page is a summary of adverse reactions, contraindications, warning and precautions.

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It can help get his mind off his knee.

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For osteoarthritic knees, spines, shoulders, hips, etc.:

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Tandearil, oxyphenbutazone:
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Contraindications: Edema, danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently.

Warning: This drug is an analog of phenylbutazone; sensitive patients may be cross-reactive. If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Persistent or severe dyspepsia may indicate peptic ulcer; perform upper gastrointestinal x-ray diagnostic tests if drug is continued. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with caution in the first trimester of pregnancy, and in patients with thyroid disease.

Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patients should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia), sudden weight gain (water retention), skin reactions, black or tarry stools or other evidence of intestinal hemorrhage occur. Make complete blood counts at weekly intervals during early therapy and at 2-week intervals thereafter. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The more common are nausea and edema. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension, the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately after meals or with milk to minimize gastric upset. Drug rash occasionally occurs. If it does, promptly discontinue the drug. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), or a generalized allergic reaction similar to a serum sickness syndrome may occur and require permanent withdrawal of medication. Agranulocytosis can occur suddenly in spite of regular, repeated normal white counts. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity angiitis, pericarditis and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

Dosage in Osteoarthritis: Initial: 3 to 6 tablets daily in divided doses. Usually unnecessary to exceed 4 tablets daily. A trial period of one week is considered adequate to determine the therapeutic effect of the drug. Maintenance: Effective level often achieved with 1 or 2 tablets daily, should not exceed 4 tablets daily.

In selecting appropriate dosage in any specific case, consideration should be given to the patient's weight, general health, age and any other factors influencing drug response.

Availability: Tan, round, sugar-coated tablets of 100 mg. in bottles of 100 and 1000.

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Supreme Court will include the reasons given for the dismissal of the suit.

Involved in this case was the applicability of Title 9, Section 22 of the *Code of Alabama*, 1940 (Recomp. 1958). This Section provides that every contract by which anyone is restrained from exercising a *lawful profession*, trade, or business of any kind, otherwise than is provided by two sections making exceptions, is to that extent void (emphasis added). Sections 23 and 24 of Title 9, *Code of Alabama, 1940* (Recomp. 1958) contain the exceptions to the above stated statute. Section 23 contains an exception permitting the enforcement of an agreement, by a buyer of "good will" wherein the seller is not to engage in a similar business as long as the buyer or any person deriving title to the business' good will from him, desires to carry on a like business. Section 24 sets forth, as another exception, the partnership agreement wherein partners may agree not to compete within certain defined limits for a specified time, upon the dissolution of the partnership.

It can be noted that while "lawful profession" was included within Section 22, reference to professions was omitted in the exceptions stated in Sections 23 and 24. The Supreme Court noted that an affirmative inference is created by the inclusion of "lawful profession" within Section 22 and its omission from Section 23. The Court then held that the covenant sought to be enforced was therefore contrary to Alabama law.

The Court further noted that the "association" in question could not be construed as a partnership so as to bring it within the exception stated in Section 24. Two essential elements of a partnership; a division of the profits and a liability for losses which may be incurred were lacking within the terms of the agreement in question. The respondent was salaried and was in no way obligated for any losses which might be incurred.

Evidence presented before the Trial Judge failed to prove any substantial financial loss to the complainant. Other testimony presented in the Trial Court indicated an acute need for physicians trained in the otolaryngology specialty existed in the geographical area concerned.

The Supreme Court noted that agreements restricting the practice of medicine had been previously enforced. The complainant relied heavily upon an 1895 decision in which the Alabama Supreme Court upheld a right to prevent one from practicing medicine pursuant to an agreement not to do so. The Court pointed out however, that, in that case, the sale of the practice had been involved and, too, that the case was decided prior to the enactment of the statutory sections discussed earlier.

The decision in this case has generated considerable interest among persons interested in the legal aspects of the practice of medicine. The Supreme Court, affirming the Trial Court's decision, noted that the interest of the general public must be considered in cases involving such restrictive covenants. This prevents injury from resulting to the public by the enforcement of these covenants. Those cases in which enforcement was upheld had been decided some 30 years or more ago; and at that time, the shortage of physicians was not so pronounced. The Court held that to enjoin the respondent physician would be contrary to public policy in this instance and against the best interest of the people since a highly trained specialist would be removed from practicing his profession in an area wherein a need existed for his services.

While the Court's decision considered fully the statutory questions involved; obviously, much weight was given to the fact that a shortage of physicians does exist and the needs of the general public should not be overlooked.

Investment Opportunities In Leisure

W. L. Whiting, III*

Today Americans are spending almost $150 billion in pursuing pleasure or ways to use their free time. Since the turn of the century, automation and greater productivity have reduced the average work week from 60 to 40 hours. Some observers foresee a 30-hour week and a proportionately higher increase in income by the year 2000. Attitudes also seem to be changing as leisure is being accepted as a meaningful necessary part of life.

Although there is no leisure industry per se, thousands of companies such as hotels and restaurants produce goods as provided services for leisure activities.

More money is spent each year for food prepared outside the home—quick snacks, take-out meals or specialties, and complete meals in luxury restaurants. The average American eats one of every four meals away from home and he will eat one of every three meals away from home by 1975. Restaurant chains have been growing at a rate of 15% a year.

McDonald's growth in the last eight years has been dramatic; system sales have climbed from $54 million to $266 million in 1967. Last year McDonald's units sold approximately 670-million hamburgers; they used 67-million pounds of beef, 55-million dozen buns, one-million gallons of catsup, one-million gallons of sliced pickles, and nine-million pounds of cheese. With sales of hamburgers currently exceeding two-million a day, McDonald's more than 1,000 operators look forward to changing the number on their familiar sign, which reads: "over 4 billion served."

McDonald's financial record has been equally impressive. In the last four years net income has increased fivefold—to $1.19 a share in 1967. Strong acceptance of McDonald's hamburgers among consumers and the demonstrated competence of management suggest that the company will be able to maintain rapid growth of earnings by expanding its franchise system, increasing its unit volume, acquiring existing franchises, and entering other areas of the fast-service food business. We estimate 1968 earnings at $1.60 a share. On the basis of that estimate and the company's long-term potential, we consider the speculative stock to be an attractive commitment for growth.

The entire travel market seems destined to soar as Americans find more time and money to satisfy their wanderlust. Motels, once places to stay en route to a destination, are frequently the destination today. To attract vacationers, many hotels have added recreation areas and entertainment facilities.

Hilton seems to be well situated to benefit from the growth projected for pleasure travel as well as business travel. Currently, 62 properties with about 36,000 rooms are identified with the Hilton or Statler Hilton names. As a result of the spin-off of Hilton International in 1964, the company's operations are now confined to the United States. With an exceptionally strong position in Hawaii, the company should share in that state's boom in tourism. By early 1969, the company will be operating facilities containing about 2,700 rooms and apartments, or some 8% of all

*I am pleased to have the opportunity to write this column every month for the Journal of the Medical Association of the State of Alabama.

I hope the reader will find the forthcoming articles interesting as well as profitable.

available accommodations in the fiftieth state.

Hilton's exceptional record of earnings gains since 1964 should be extended in coming years. We believe that the company's long-term prospects are favored by the planned expansion of the Hilton chain, rising occupancy rates, and the increasing profitability of food-and-beverage operations (which accounted for 42% of 1967 revenues). Results should also be aided by growing income from the franchising of Statler Hilton Inns and facilities operated under management contracts and by the probable sale of less profitable properties. Consolidation of majority-owned subsidiaries would also add to per-share earnings.

All indications are that the overall leisure market will keep on growing. We believe that it will reach $250 billion by 1975. What is more, we at Merrill Lynch believe that leisure will be the dynamic element in the domestic economy in the 1970's and that it will even out perform the economy.

For additional information write P. O. Box 1602, Mobile, Alabama 36601.

Two Fatalities Eyed By Medical Aspects Of Sports Committee

A report assembled for the Medical Aspects of Sports Committee, of which Dr. Ellis F. Porch of Arab, Ala., is chairman, lists two fatalities directly attributable to football thus far this season, and one permanent paralysis.

In Clay County, a Lineville boy suffered a head injury in mid-September. Subsequently he complained of severe headaches. Dr. George C. Smith of Trussville reports that he examined the boy thoroughly, and both examination and X-rays were negative. When the headaches continued, Dr. Smith sent him to neurosurgeons in Birmingham. They also found nothing, and the boy was advised as a precautionary measure that he should skip at least the football game scheduled for the following Saturday.

This he did. But the second Saturday he played, and Dr. Smith reports:

"I was on the sidelines with the coach. Carrying the ball, the boy was tackled. It was not a particularly hard tackle; at least it didn't look so from where we stood. When he got to his feet, he started a wobbly course toward the sidelines. The coach and I ran to him, and he collapsed in a coma just as we reached him. We took him to the hospital. Blood pressure and pulse increased fast. He was dead within an hour.

"There was no autopsy. But it seems evident, from the medical history of the case, that he suffered an aneurysm."

The second fatality stemmed from similar circumstances. A Trussville boy, William Hicks, suffering from a similar head injury received early in the season, collapsed after tackling a ball carrier. His head struck his opponent in the chest. The unconscious boy was taken to neurosurgeons in Birmingham, where he died shortly afterward.

Although the boy was not a patient at the time of Dr. William D. Thompson of Trussville, the doctor was a witness to it. He discounted the idea of "spearing," saying that such procedure would have caused a neck injury to the tackler. He is believed to have suffered an aneurysm caused by the blow on his head earlier in the season.

A third victim of this same kind of accident, a Prattville boy, survived a brain hemorrhage but is permanently incapacitated by paralysis.

Health Needs And Resources Of 13 Alabama Counties

Thirteen Alabama counties were put under a statistical microscope and presented some significant health contrasts, according to a short summary just released by Miss Ida Martha Reed, Field Study Coordinator, Bureau of Research and Community Service. The findings follow:

MORGAN, LAWRENCE, LIMESTONE COUNTIES

The Morgan, Lawrence, and Limestone County areas appear to be relatively sufficient in terms of medical services. When discharges from all hospitals were combined, 89 per cent were found to be residents of the Tri-county area.

The population of the Tri-county area is younger than that of Alabama and the United States. The percentage of the population 65 years and over is smaller in the Tri-county area than in the United States.

The 3 counties offer stark contrasts in socio-economic character. Morgan County has developed industrially because of its location in the Tennessee Valley Region and its close proximity to the Tennessee River. Morgan County is ranked 1,464 out of 3,134 counties in the nation in terms of family income.

The socio-economic character of Lawrence County is far different from that of Morgan County. Income level has experienced only limited growth and only two industries are located in the county.

Because of its close proximity to the space center at Huntsville, Limestone County is undergoing substantial economic growth, although like Lawrence County, it is much poorer than Morgan County. This county ranks 2,470 out of 3,134 counties in the United States in terms of median family income.

Because of shortages of health manpower, there are unopened health care facilities, closed nursing units in hospitals, and numerous unfilled positions for health workers.

MACON COUNTY

Macon County, with a predominantly no white population, had an infant death ra almost twice as great as the state rate.

The County ranked 17 from the bottom i terms of family income level. Housing co ditions were listed as poor—only 39.1 p cent of the rural farm units were classifie as sound. More than half of the housin units in the county reported no sewage dis posal facilities.

Unique potential exists, through Tuske gee Institute, for the development of para medical educational programs.

CRENSHAW COUNTY

Only 42 per cent of Crenshaw County ma ternity patients delivered in Crenshaw Coun ty. The birth rate was lower than that o the state or nation while the death rate was higher than either.

Over 63 per cent of all housing units use some means of sewage disposal other than public sewers, septic tanks, or cesspools.

LEE COUNTY

Eighty-six per cent of the patients treated in the Lee County Hospital were residents of the county. This supports the observation that the Auburn-Opelika area is a relatively self-contained medical service region.

The birth rate in Lee County was higher than the state or national experience. The death rate and fetal death rate were well below the state rate.

Lee County is one of the more progressive economic areas of the state. The personal income, per capita income, and median family income have continually risen since 1947. Seventy-one per cent of the housing in Lee County is considered sound.

(Continued on Page 565)

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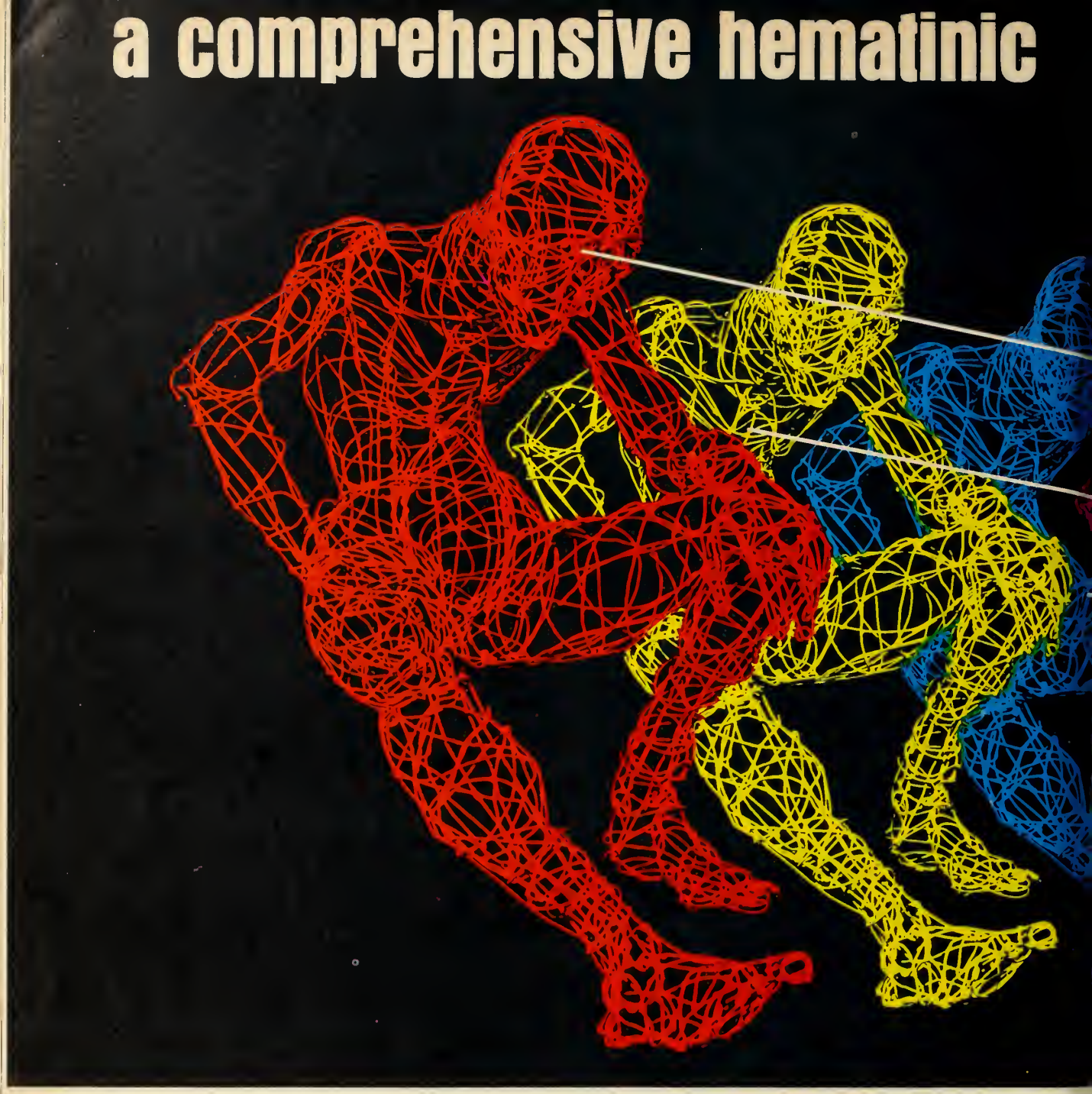
DILANTIN is useful in the treatment of grand mal epilepsy and certain other convulsive states. Its use will prevent or greatly reduce the incidence and severity of convulsive seizures in a substantial percentage of epileptic patients, without the hypnotic and narcotizing effects of many anticonvulsant drugs.
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DILANTIN is supplied in several forms including Kapseals® containing 0.1 Gm. and 0.03 Gm. diphenylhydantoin sodium.
Parke, Davis & Company, Detroit, Michigan 48232

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scription: Each Pulvule® contains—

ecial Liver-Stomach Concentrate, Lilly containing Intrinsic Factor)	150	mg.
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The total vitamin B_{12} activity in the Special Liver-Stomach Concentrate, Lilly, and the Cobalamin Concentrate, N.F., is 5 micrograms.)		
n, Elemental (as Ferrous Fumarate)	110	mg.
corbic Acid (Vitamin C)	75	mg.
ic Acid	1	mg.

lications: Trinsicon® (hematinic concentrate with intrinsic fac-, Lilly) is a multifactor preparation effective in the treatment anemias that respond to oral hematinics, including pernicious emia and other megaloblastic anemias and also iron-deficiency emia.

Contraindications: Hemochromatosis and hemosiderosis.

Precautions: Anemia is a manifestation that requires appropriate investigation to determine its cause or causes.

In pernicious anemia, the use of folic acid without adequate vitamin B_{12} therapy may result in hematologic remission but neurological progression. Adequate doses of vitamin B_{12} (parenteral, or oral with potent intrinsic factor as in Trinsicon® [hematinic concentrate with intrinsic factor, Lilly]) usually prevent, halt, or improve the neurological changes.

As with all preparations containing intrinsic factor, resistance may develop in some cases of pernicious anemia to the potentiation of absorption of physiological doses of vitamin B_{12}. If resistance occurs, parenteral therapy, or oral therapy with so-called massive doses of vitamin B_{12}, may be necessary. No single regimen fits all cases, and the status of the patient observed in follow-up is the final criterion for adequacy of therapy. Periodic



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Folic acid (1 mg.)—treats nutritional macrocytic anemias and/or malabsorption syndromes.

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clinical and laboratory studies are considered essential and are recommended.

Adverse Reactions: In rare instances, iron in therapeutic doses produces gastro-intestinal reactions, such as diarrhea or constipation. Reducing the dose and administering it with meals will minimize these effects.

In extremely rare instances, skin rash suggesting allergy has followed oral administration of liver-stomach material. Instances of apparent allergic sensitization have also been reported after oral administration of folic acid.

Dosage: One Pulvule twice a day. (Two Pulvules daily produce a standard response in the average uncomplicated case of pernicious anemia.)

How Supplied: Pulvules Trinsicon® (hematinic concentrate with intrinsic factor, Lilly), in bottles of 60 and 500. [032568]

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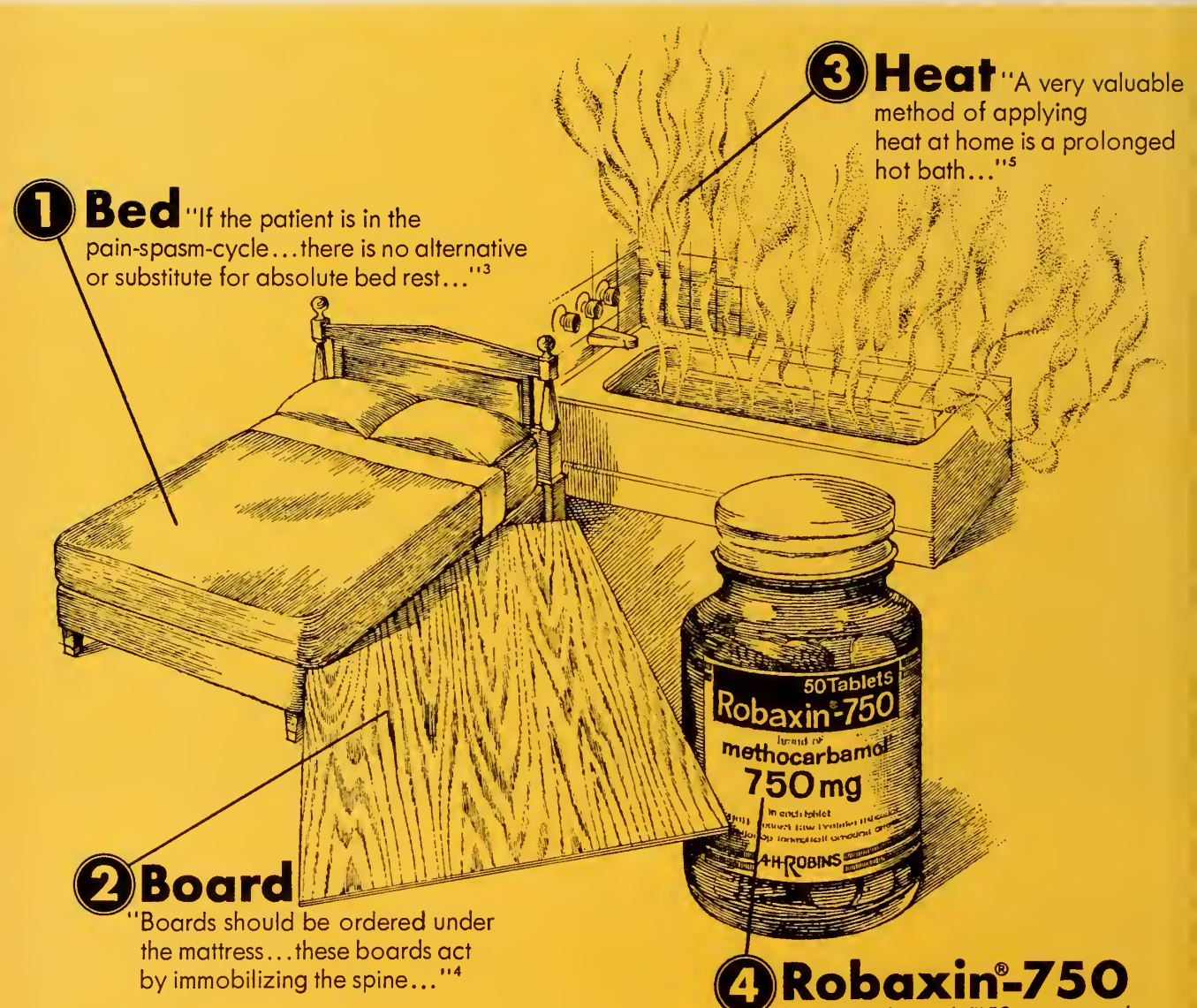
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2 Board "Boards should be ordered under the mattress...these boards act by immobilizing the spine..."[4]

3 Heat "A very valuable method of applying heat at home is a prolonged hot bath..."[5]

4 Robaxin®-750 (methocarbamol, 750 mg. capsule-shaped tablets) A well-tolerated[6] skeletal muscle relaxant, methocarbamol helps relieve spasm "...without interfering with normal tone and movement."[7] And there is little likelihood of sedation.[6]

Indicated far relief af skeletol muscle spasm. **Contraindicated** in hypersensitive patients. **Side Effects** (lightheadedness, dizziness, drowsiness, nousea) may occur rorely, but usually disappear an reduced dasage. Hypersensitivity reactians develop infrequently. See product literature for further details. **Also available:** Robaxin® Tablets (methacarbomol, 500 mg.) Rabaxin Injectoble (methacarbomal, 1 Gm./10 cc.)

References: (1). Gadfrey, C.M.: Applied Therap. 8:950, 1966. (2). Gottschalk, L.A.: GP 33:91, 1966. (3). Rawe, M.L.: J. Occup. Med. 2:219, 1960. (4). Cazen, L.: Sauth Dakata J. Med. 18:26, 1965. (5). Sato-Hall, R.: Med. Sc. 14:23, 1963. (6). Weiss, M. and Weiss, S.: J. Am. Osteapath. A. 62:142, 1962. (7). Feuer, S.G., *et al.*: New York J. Med. 62:1985, 1962.

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(Continued from Page 560)

PIKE COUNTY

Pike County had the highest death rate of all Alabama counties in 1966. Also, the fetal death rate is extremely high.

Most of the socio-economic indicators reflect potential barriers to financing sound medical care programs: low family income, lack of large scale industrial growth, and the failure of agricultural prices to keep pace with the high cost of living. Over 52 per cent of all housing units use some means other than public sewers, septic tanks or cesspools for sewage disposal.

At present, neither of the hospitals located in Pike County conforms to minimum U. S. Public Health Service Safety Standards. The opening of the new Edge Memorial Hospital in July, 1969, will be a positive step toward replacing inadequate facilities.

COLBERT, FRANKLIN, LAUDERDALE COUNTIES

Low fetal death rates were reported in the three-county area. Also low birth rates and death rates were reported.

Of the three counties, Franklin County appears to be the most under developed, in terms of personal income, housing conditions, and environmental health problems.

Hospitals and health departments reported needs for additional manpower, equipment and resources.

Excellent opportunities exist for training health manpower through the trade school, junior college and 4 year college located in the area.

HOUSTON COUNTY

It was found that 38 per cent of the patients treated in Houston County hospitals resided outside of the county. This served as support for the observation that Dothan serves as a medical referral center for Southeast Alabama.

The County reported higher death rates and fetal death rates than the state.

The County lags far behind the state median family income. Nearly one-fourth of the housing units in the county use means other than septic tanks or sanitary sewers to dispose of sewage.

TALLADEGA COUNTY

Hospital facilities in Talladega County are serving a localized patient population. The high percentage utilization appears to be due to the strategic locations of the two hospitals within the county—one being located in the North and one in the South.

A large proportion of the population in the county is under 15 years of age and over 45—the two age groups that consume the largest share of health care services than the middle age citizens.

Considerable growth in personal income was reported in Talladega County since 1950. Nearly one-third of all housing units do not use public sewers, septic tanks or cesspools.

COFFEE COUNTY

Coffee County reported low median family income and a lack of large scale industrial growth, but an increase in the level of education.

Coffee County reported a large proportion of persons over 65 years of age. This indicates an increasing demand for chronic care services.

Coffee County is fortunate to have a multispecialty group practice clinic in Enterprise which is providing a superior quality of medical care to its patients.



around the state

Story In Pictures of Calhoun's Successful Seminar





From left (top picture): Dr. Russell J. Leonard, vice president of county society and seminar moderator; Dr. John J. Jackson, professor, Medical Genetics, University of Mississippi, program speaker; Dr. and Mrs. Robert L. Elliott, Jr., and Dr. William O. Barnett, professor of Surgery, University of Mississippi, also a program speaker. . . . Next picture, immediately above, from left: Dr. J. Patrick Stewart, society secretary; Dr. John R. (Jack) Morris, Calhoun society president; Dr. J. Scott Butterworth, Associate Professor of Medicine, New York University, and Dr. David L. Barclay, professor, Obstetrics and Gynecology, Tulane, both seminar speakers; and Dr. John A. Edwards, Jr., Anniston. . . . Finally, right: Drs. Warren G. Sarrell and Henry L. Laws, II, of Anniston.





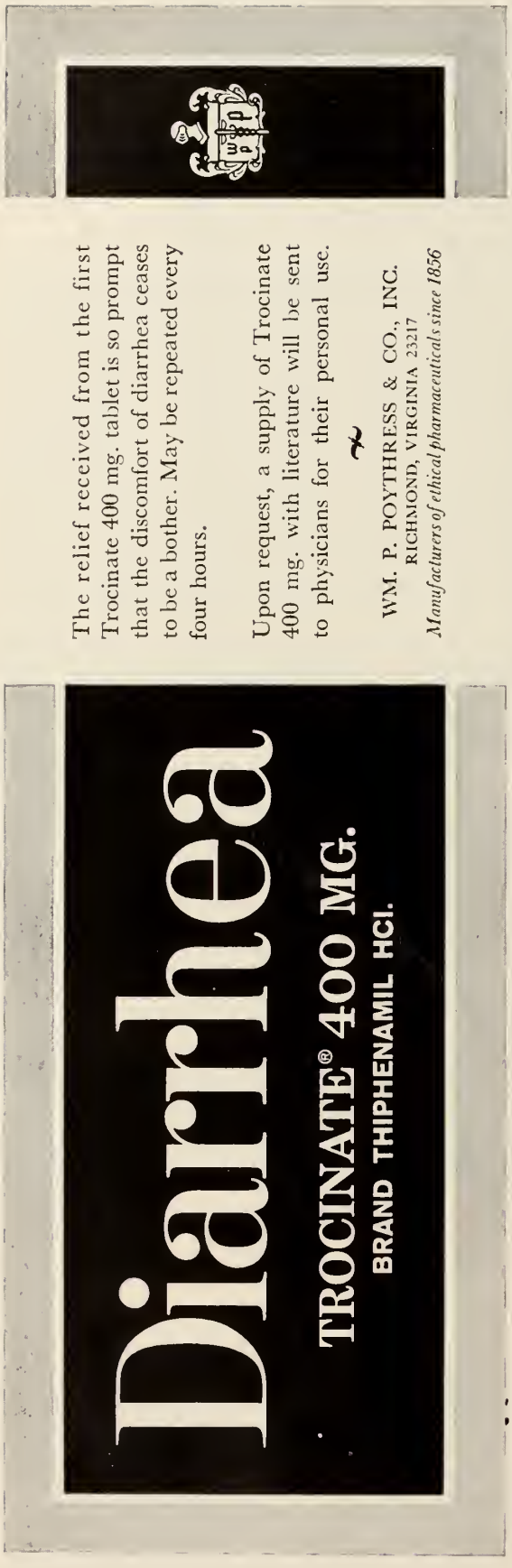
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Vital Statistics

NEW MEMBERS

Houston County

Faulk, Charles Jennings, III b 34, mc Ala. 59, sb 59, P. O. Box 2016, Dothan, Ala. 36301. P—792-1113

Jefferson County

Baxley, William Allison, b 33, mc Duke Univ. 62, recip N. C. 66, 1919-7th Avenue South, Birmingham, Ala. 35233. C—325-4011

Beck, Ronald Vance, b 39, mc Ala. 65, sb 66, Lloyd Noland Hospital, Fairfield, Ala. 35064. ObG—785-2121

Briggs, Dick Dowling, Jr., b 34, mc Wash Univ. 60, recip Mo. 64, Carraway Methodist Hospital, Birmingham, Ala. 35234. I—251-4231

Caceres, Jorge Alberto, b 33, mc San Marcos Univ. 59, sb 67, Lloyd Noland Hospital, Fairfield, Ala. 35064. ALR—785-2121

Capra, Charles Samuel, b 35, mc Ala. 66, recip NBME 67, 1919-7th Avenue South, Birmingham, Ala. 35233. P—325-4011

Carey, Joshua Harlan, b 16, mc Univ. Chicago 44, recip Ill. 67, 1919-7th Avenue South, Birmingham, Ala. 35233. Pd—325-4011

Colvin, Charles Henry, III, b 37, mc Duke Univ. 62, recip N. C. 68, 1701-9th Avenue South, Birmingham, Ala. 35205. I—251-0141

Ingle, Leo Ray, Jr., b 38, mc Ind. Univ. 67, recip Ind. 68, 412-4th Avenue North, Bessemer, Ala. 35020. GP

Matthews, James Claude, Jr., b 43, mc Ala. 67, sb 68, Lloyd Noland Hospital, Fairfield, Ala. 35064. S—785-2121

Shin, Myung Soo, b 30, mc Seoul National Univ. 56, Limited license 68, 619 South 19th Street, Birmingham, Ala. 35233. R

Madison County

Bell, William Hugh, III, b 34, mc Tenn. 60,

recip Tenn. 68, 401 Lowell Drive, Huntsville, Ala. 35801. NS—539-4112

Richardson, James Whyteman, b 36, mc Emory 65, recip Ga. 68, 101 Sivley Road, Huntsville, Ala. 35801. GP

Morgan County

Payne, Louis Thomason, b 39, mc Ala. 64, sb 65, Medical Arts Building, West Pine Street, Hartselle, Ala. 35640. ObG—773-6553

Royer, William Albert, b 32, mc Ala. 57, sb 58, 811-6th Avenue SE, Decatur, Ala. 35601. P—355-4905

Sidwell, Walter Frank, b 32, mc Tenn. 55, recip Fla. 67, 1202-13th Avenue SE, Suite B, Decatur, Ala. 35601. OALR—355-7240

Trammell, Dale Edward, b 37, mc Ala. 61, sb 62, 1201 Somerville Road SE, Decatur, Ala. 35601. S—353-7621

DEATHS

Marengo County

Kimbrough, Cecil Emmett, Linden, Ala. 36748—deceased October, 1968.

Montgomery County

Jabour, Ernest Puck, 243 South Jackson Street, Montgomery, Ala. 36104—deceased September 30, 1968.

CHANGE OF ADDRESS—MEMBERS

Cherokee County

Burns, James H., present Centre, Ala. 35960, to 508 Martin Lane, Augusta, Ga. 31904.

Coffee County

Lumpkin, T. Riley, present Enterprise, Ala. 36330, to Professional Arts Building, Brown Circle, Enterprise, Ala. 36330.

Houston County

Moffett, Paul R., present Dothan, Ala. 36301, to 211 West Main Street, Dothan, Ala. 36301.

Jefferson County

Coston, Ralls M., present Birmingham, Ala. 35209, to 1715 Wellington Road, Birmingham, Ala. 35209.

Johnston, Eugene R., present Birmingham, Ala. 35205, to 1025 South 18th Street, Birmingham, Ala. 35205.

King, William D., Jr., present Birmingham, Ala. 35205, to 1025 South 18th Street, Birmingham, Ala. 35205.

Malkoff, Donald B., present Birmingham, Ala. 35205, to 2233 Huntington Drive, San Marino, Calif. 91108.

Lauderdale County

Brown, Harry G., present Florence, Ala. 35630, to Box 798, Florence, Ala. 35630.

Butler, William G., Jr., present Florence, Ala. 35630, to Box 798, Florence, Ala. 35630.

Cox, Rabon B., Jr., present Florence, Ala. 35630, to Box 798, Florence, Ala. 35630.

House, John O., present Madison, Tenn. 37115, to P. O. Box 8422, Chattanooga, Tenn. 37411.

Lee County

May, J. T., present Opelika, Ala. 36801, to 490 Brantwood Road, Snyder, N. Y. 14226.

Madison County

Broyles, John A., III, present Huntsville, Ala. 35801, to 5307 H. Paquette Street, Ft. Knox, Ky. 40121.

Moore, Billy S., present Huntsville, Ala. 35801, to 7901 Westhaven Drive, Huntsville, Ala. 35801.

Montgomery County

Byrne, Haynes C., present Montgomery, Ala. 36104, to 1000 Adams Street, Montgomery, Ala. 36104.

Parker, Robert, present Montgomery, Ala. 36104, to 2900 McGehee Road, Montgomery, Ala. 36111.

Stern, Louis H., present Marrero, La. 70072, to 5701 Albany Court, New Orleans, La. 70114.



Norman and Duke

A Boxer Stands Guard Over U. S. Mail

"The mail must go through!" was the pledge of pony express riders in the days when war-painted Indians and blood-thirsty outlaws lurked in many a hiding place along the way.

"The mail must go through!" resolved Army airmail pilots of 40 years ago, as they headed their flimsy flying machines into all kinds of threatening weather.

Duke, a hard-muscled Boxer, says much the same thing with bared teeth to any neighborhood dog that would yap at the wheels of the Postoffice vehicle piloted by Postman Norman Wientjes, along the circuitous south Montgomery route he travels each weekday.

A dozen of the 15 doctors on this route out of the Green Lantern suburban postoffice are members of the Medical Association of the State of Alabama. Of the other three, Dr. H. Ray Evans, Jr., is a dentist, Dr. Thomas S. Hosty is a Ph. D., director, Bureau of Laboratories of the State Health Department, and Dr. Charles L. Gantt is an optometrist.

The 12 doctors listed alphabetically in the MASA Roster are:

Drs. Jesse D. Baggett, Thomas S. Boozer, Haynes C. Byrne, Jack P. Evans, Edgar G. Givhan, Bruce F. Holding, Jr., Robert M. Lightfoot, Arthur F. Lincoln, E. Rogers Nodine, H. L. Rosen, S. J. Selikoff, and Albert S. Zdanis.

Almost any delivery day, when you see the motorized vehicle of Postman Wientjes

parked while he delivers mail by hand, Duke, is nearby. He may be resting in the shade across the street, but he will be within watching distance of the mail. The exceptions will be the days that Wientjes is off and a substitute postman on his route. Duke accepts no substitutes!

It all began less than a year ago, when the postman made friends with the big Boxer that guarded the home of the Jay Johnsons on Lansdowne. One day, returning to his vehicle from delivering mail in the vicinity, he found Duke had adopted him and was sitting in the seat beside the steering wheel. The dog has been riding with Wientjes ever since. And when Zone 11 was separated from Zone 6, moved from Carolyn Station to the just-built Green Lantern, Duke learned quickly that he could report for duty at the start of the route and accompany his foster master the entire way around. He does that to this day.

There is one curious departure from Duke's routine protection of the mail. When he and his responsibility reach the vicinity of 2804 North Colonial Drive, the big Boxer insists on staying inside the mail truck; either that or he cowers close to the postman's legs, whimpering.

There is good reason. For this address is the home of the Fred Bowman Bears and their big white German shepherd, 'Udolph. And that story is worth an extra paragraph.

'Udolph was nabbed by his 4-year-old mistress for the red-nosed reindeer. Already, as a tiny puppy, he worshipped this little daughter of the Bears. So when an overgrown Boxer puppy named Duke would pursue the child on her tricycle, barking to frighten her, tiny 'Udolph would yap indignantly . . . and helplessly. He never forgot. Today Duke wear numerous scars of combat, received when 'Udolph outgrew him.

If 'Udolph would forgive and Duke would forget, it would be a good thing. And Postman Norman Wientjes is making every effort to have them shake paws!

BRIEFS

Common diseases and disorders of man, so long accepted as of no deep significance, may prove the reverse to be true, a panel of life insurance medical directors has agreed. A St. Louis association meeting agreed that the "peptic ulcer, polyps, vertigo and hiatal hernia . . . may develop, or be part of, a more serious condition leading to increased mortality."

* * *

Doctors at Pacific State Hospital (for the mentally retarded) use a computer to ascertain which ones of their patients run a relatively high risk of death in the early months after admission. They have found the projections help to prevent death. The idea grew out of the fact that patients with certain characteristics were more likely to die while hospitalized than others.

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Alabama Department of Public Health

A Review And Analysis Of Phenylketonuria From Discovery To Alabama's Formative Years*

By

Forest E. Ludden, M. P. H., Director

Bureau of Primary Prevention

Alabama's Formative Years

Almost 30 years elapsed between the discovery of PKU by Dr. Asbjorn Folling, a Norwegian biochemist and physician, and the inception of a program in Alabama. This may be partially explained by the natural evolutionary process which must necessarily preclude such programs. The scientific community had to explore, sift, and alter the experimentation being done. By the mid-1950's definite patterns had been established.

The job of bringing data together and educating the private practitioner of medicine commenced, and scattered programs were set up around the country. By 1960 specialists at the University of Alabama Medical School became interested. Almost simultaneously, officials of the Alabama Department of Public Health, under the guidance of the State Board of Health, began to attend professional meetings dealing with the problems of PKU as it related to mental retardation. From this modest beginning a whole new program evolved in Alabama.

The First Memorandum

On April 19, 1961, a memorandum from Dr. Harold Klingler, director, Bureau of Maternal and Child Health, and Dr. Thomas Hosty, director, Bureau of Laboratories, Alabama Department of Public Health, notified county health officers of the availability of reagents for PKU testing through county well-baby clinics. The gentle phrases used indicated a suggestive procedure only to avoid an interpretation by county personnel that another procedure was being added to an already heavy work load. Repeatedly, complaints were being registered that a critical shortage of public health professionals was present.

For the next two years Dr. Klingler and Dr. Hosty visited hospitals throughout the state to enlist their cooperation in the testing program.

Almost concurrently major administrative decisions were being made concerning training central laboratory personnel to process specimens that eventually would be sent for analysis. A laboratory division director and a bacteriologist were sent to Boston to work with Dr. Robert A. MacCready of the Massachusetts State Health Department and Dr. Ephrong, a noted biochemist. Massachusetts's state laboratory had served as a pioneer in the United States in the area of PKU testing.

Implementation of a PKU program in Alabama, however, was dependent upon securing additional space, equipment, and trained personnel. Final decisions also had to be made concerning the most reliable test for diagnosing PKU. It had been determined that the urine test was not as reliable as had been re-

*Excerpted from a doctoral term paper.

*Total positives since the program was begun in November, 1964—12.

ported. It was decided to use Partlow School as a testing center and to compare results.

A few years prior to 1963, University of Alabama personnel had run urine tests at Partlow. These could serve as a checkpoint and as a control point for the accuracy of the urine test versus other tests. It might be noted that it was not the purpose of the state laboratory to redo what had already been done, but rather to establish the validity of techniques to be employed in a state-wide testing program.

A number of staff members went to Partlow and "bled" 2100 youngsters in two days. These samples were sent to the central lab "blind." Tests were run and results correlated. Identical results were obtained. In addition, three other cases were found that had not been diagnosed as PKU cases. The Guthrie test was selected as the most reliable method. By the end of 1963 the state laboratory felt confident that they were ready to receive any and all samples from around the state.

A Critical Time

By mid-year, 1964, all 67 county health departments were strongly urged to take urine samples from all prenatal cases that were examined in their clinics. Any mother presenting PKU had to be reported to the Bureau of Maternal and Child Health, and a consultation visit would be made to assist this mother.

During the year, Dr. Hosty visited and revisited hospitals in the state to interest them in taking blood samples of new-born infants with the state laboratory running the tests free of charge.

In November of the same year, a memorandum was distributed to county health departments entitled "Blood Testing for PKU." The main body contained the following:

> Through the cooperation of the Bureau of Laboratories of the state health department, a service is now available for the testing of blood specimens for phenylketonuria.
>
> This program is not to displace our urine testing program, although blood testing has many advantages over the testing of urine specimens. It is impractical in many of our county health departments to obtain a blood specimen.
>
> Any county interested in blood testing for phenylketonuria may obtain all directions and materials from the Bureau of Laboratories which has already offered this service to any hospital in the state wishing to cooperate.

At this particular time the state health department, specifically the laboratory, was in a financial crisis. Two branch laboratories in the state had to be closed because of insufficient funds. If the PKU testing program was to be continued, outside sources of revenue had to be obtained. The needed funds were secured from the Children's Bureau, the federal agency with prime responsibility for

(Continued on Page 576)



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Even the office boy has problems... and he's the boss' nephew.

The business day is full of insanity, incompetence and interruptions...a thousand little things that may cause tension headaches.

Life in the office may get more complicated, but now treatment of the tension headache is simpler—with Dialog! Here's effective nonsalicylate analgesia plus mild sedation. Relieves tension. Relieves pain.

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INDICATIONS: For relief of pain and discomfort of simple headache; neuralgia, myalgia, and musculoskeletal pain; dysmenorrhea; bursitis; sinusitis; fibrositis. Also indicated to reduce fever and to relieve discomfort due to respiratory infections, influenza, and other febrile conditions.

CONTRAINDICATIONS: Not recommended during pregnancy.

WARNINGS: May be habit-forming. Do not use in patients sensitive to barbiturates or in those with moderate to severe hepatic disease.

ADVERSE REACTIONS: Nausea, transitory dizziness, rash. Overdosage of allobarbital produces symptoms typical of acute barbiturate excess.

DOSAGE: Adults: 1 or 2 tablets every 4 hours. Not to exceed 8 tablets in 24 hours. Children 6 to 12: 1/2 to 1 tablet every 4 hours. Not to exeecd 4 tablets in 24 hours.

SUPPLIED: Tablets (white, scored), each containing 15 mg allobarbital and 300 mg acetaminophen; units of 3, bottles of 30.

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CIBA

(Continued from Page 573)

maternal and child health care. From this point the Alabama PKU program has been totally supported by federal monies.

The first hospital to cooperate in this program was St. Margaret's Hospital in Montgomery which at that time had a full time pathologist. Staff members of the hospital and laboratory met and worked out program details.

In the 1964 annual report of the Alabama Department of Public Health, the following information was given concerning the PKU program:

> A new procedure, the screening of infants for phenylketonuria, was started in October. Bloods from 2106 patients at Partlow State School were tested at the beginning of the program, and 18 were found to be positive.
>
> In addition to this project, 935 specimens from hospitals and physicians of the state had been tested by the end of the year and one was found to be positive.

A Child is Found

Before the first hospital entered the testing program in late 1964, the laboratory found a PKU child in north Alabama. Through information from an out-of-state physician, who had diagnosed PKU in an older child in the family, the second child was tested by the state health department laboratory. The results were positive. This case is not considered to be the first found by the laboratory routinely because of the known family history of the disease. The end result of this case is a human tragedy. The child was getting along very well on the diet and appeared bright, but crawled out of the yard, fell into a creek, and drowned.

The very first baby found by a routine sample was born in Montgomery on February 7, 1965. Since February, 1965, this child has been on a PKU diet, the cost of which averages between $2.50 and $3.00 per day. To meet this expense the Bureau of Maternal and Child Health of the state health department provides diets free of charge to all families with PKU children.

Laws and Obstacles

There were two other major developments in 1965. The first concerned a law written by the state mental health group and introduced in the legislature by Senator Carter. This act made it mandatory for each institution, physician, or person attending infants 28 days or less in age to have administered a reliable test for PKU. Act No. 885 was signed by the governor at the end of the legislative session and is presented here as a reference.

ALABAMA LAW
(Regular Session, 1965)

Act No. 885 S. 9—Carter

AN ACT

Relating to public health; to require the testing and treatment of infants for phenylketonuria; to authorize and direct the state board of health to promulgate rules and regulations to accomplish the purpose of this Act.

Be It Enacted by the Legislature of Alabama:

Section 1. It shall be the duty of the administrative officer or other person in charge of each institution caring for infants twenty-eight days or less of age, or the physician attending a newborn child, or the person attending a newborn child, or the person attending a newborn child that was not attended by a physician, to cause to have administered to every such infant or child in his care a reliable test for phenylketonuria (PKU), such as the Guthrie Test or any other test considered equally reliable by the state board of health. Testing and the recording of the results of such tests shall be performed at such times and in such manner as may be prescribed by the state board of health. Provided, that no such test shall be given to

any child whose parents object thereto on the grounds that such tests conflict with their religious tenets and practices.

Section 2. The state board of health shall promulgate such rules and regulations as it considers necessary to provide for the care and treatment of those newborn infants whose tests are determined positive, including but not limited to advising dietary treatment for such infants. The state board of health shall promulgate any other rules and regulations necessary to effectuate the provisions of this Act.

Section 3. The provisions of this Act are severable. If any part of the Act is declared invalid or unconstitutional, such declaration shall not affect the part which remains.

Section 4. All laws or parts of laws which conflict with this Act are repealed.

Section 5. This Act shall become effective on the first day of the second month following its passage and approval by the Governor, or its otherwise becoming a law.

Approved September 5, 1965.

Time: 11:05 A. M.

I hereby certify that the foregoing copy of an Act of the Legislature of Alabama has been compared with the enrolled Act and it is a true and correct copy thereof.

Given under my hand this 9th day of September, 1965.

McDOWELL LEE
Secretary of Senate

It must be stated that the State Board of Health, the Alabama Department of Public Health, and private physicians did not support the bill, nor did they oppose it. Reasons for this position follow:

Before the law was passed certain hospitals in the state were opposed to taking samples and sending them into the laboratory.

In the annual report of the Alabama Department of Public Health for 1965, the following summary was given:

The PKU program, started only last year, has been well worth the effort expended on it since during this period of time four positive children have been detected and are now under dietary treatment.

	Number Tested	Positive
Newborn (White)	17,819	3
Newborn (Colored)	2,998	0
Four Week (White)	12,949	0
Four Week (Colored)	3,174	0
Maternal PKU	4,919	0
	41,859	3*

Screening of specimens was accomplished by the Guthrie Bacterial Inhibition Assay with confirmation by both chromotography and fluorometric determinations of serum phenylalanine.

For dietary follow up, regular phenylalanine determinations were made on each of the four phenylketonuric infants diagnosed as a result of the screening program and on four older children previously diagnosed.

Each year there are approximately 70,000 live births in the state. By 1966, the laboratory was running over 60,000 specimens a year. Even though some of these specimens are on older infants and young children, evidence suggests that more hospitals and private physicians are participating. PKU testing in clinic services revealed five additional cases.

Summary

This paper has been concerned with the PKU problem in historical form. Special emphasis has been placed on the emerging Alabama program in the sixties. There is no doubt that every state should have a complete case-finding and treatment program.

Perhaps the best summary would be to quote from an interview I had with Dr.

Thomas Hosty, director, Bureau of Laboratories, Alabama Department of Public Health.

I went to a town in Alabama, the other day to see a child who had PKU found by the laboratory. I could have just bawled when I saw this child not being cared for properly. The mother, God love her, doesn't have an IQ of 60. I don't think the father is very bright either. I said to the mother, "Are you keeping the baby on a diet?" I knew quite well she wasn't because she only brings him in every couple of months. She said, "Well, he sneaks a little." Then I said, "You keep that baby on his diet for you may not think something is happening but it is."

In retrospect this child has been a problem. There was no response from the family when the laboratory sent out the second notice for this child to be rechecked for PKU. We didn't get it for two and a half months.

This child was a month and a half old when we found him. His grandmother had been quoted as saying, "You are just like your two cousins, you're lazy too." This gave us a hint and we went back to that family and tested the other children. Sure enough, both of them were irreparably damaged with PKU. Incidently, all of these are of the same family.

The grandmother put a stop to our investigation, but if we could have continued I think we would have found more children in this family with PKU. It is almost a certainty that trouble looms again because the mother is pregnant. I'm sure the two cousins are going to end up in Partlow School. I would love to go when they are having a family reunion. I tell you, that would be a free-wheeling circus if there ever was one. It just disturbs you that here you have, not the cure, but the prevention of damage and you can't put it into operation.

The Future

Every state will have a testing program. Some will centralize the program in state health department laboratories and some will utilize private and institutional laboratories.

Mead Johnson Laboratories ran a survey in 1967 indicating that 32 states had statutes on PKU testing; 41 states had active programs. This supports the thesis that in the future all states will have complete programs.

There may be a shift in the physician's role for PKU treatment. To date the family physician assumes prime responsibility for treatment. In the future there could be one or two centers set up in each state where children would be sent. In these centers, or wings of existing facilities, specialists in PKU would handle the patient and family at the critical period just after positive laboratory findings.

As more PKU children are found and treated they will be able to enter the main stream of life. This will mean greater reproduction will occur. A greater number of offspring will be carrying the recessive gene. It is possible that in the future, instead of an average of one PKU baby being born in 8,000 to 10,000, we will have one in 500 live births.

A definite need exists for establishment of a national registry of all PKU individuals. This will be particularly needed as more cases are found and if more children are born with the disease.

By the end of this century geneticists may be able to alter the genetic structure of the individual before or after birth, specifically for PKU. It may be possible to chemically change the molecular balance of the gene-enzyme relationship so that there is a normal breakdown from phenylalanine to tyrosine. This could be the utopia of a preventive program for PKU.

BUREAU OF VITAL STATISTICS
PROVISIONAL BIRTH AND DEATH STATISTICS AND COMPARATIVE DATA

Ralph W. Roberts, M. S., Director

AUGUST 1968

Live Births / Deaths / Causes of Death	Number Registered During August 1968			Rates* (Annual Basis)		
	Total	White	Non-White	1968	1967	1966
Live Births	5,665	3,744	1,921	18.6	18.7	20.2
Deaths	2,490	1,677	813	8.2	8.0	8.8
Fetal Deaths	118	56	62	20.4	18.7	16.1
Infant Deaths						
under one month	107	65	42	18.9	16.4	23.3
under one year	137	82	55	24.2	21.4	28.6
Maternal Deaths	1		1	1.7	6.9	4.9
Causes of Death						
Tuberculosis, 001-019	15	5	10	4.9	7.3	7.4
Syphilis, 020-029	4		4	1.3	0.3	1.0
Dysentery, 045-048						
Diphtheria, 055						
Whooping Cough, 056	1		1	0.3		
Meningococcal infections, 057						0.3
Poliomyelitis, 080, 081	1+	1		0.3		
Measles, 085					0.3	0.7
Malignant neoplasms, 140-205	349	252	97	114.3	125.9	122.4
Diabetes mellitus, 260	41	29	12	13.4	13.5	16.0
Pellagra, 281						
Vascular lesions of central nervous system, 330-334	333	198	135	109.1	105.8	127.7
Rheumatic fever, 400-402						0.3
Diseases of the heart, 410-443	810	603	207	265.3	257.1	286.9
Hypertension with heart disease, 440-443	83	44	39	27.2	24.8	35.8
Diseases of the arteries, 450-456	65	54	11	21.3	23.8	20.4
Influenza, 480-483					0.3	
Pneumonia, all forms, 490-493	55	36	19	18.0	16.9	14.7
Bronchitis, 500-502	3	2	1	1.0	1.7	1.0
Appendicitis, 550-553	2		2	0.7	1.0	0.7
Intestinal obstruction and hernia, 560, 561, 570	10	6	4	3.3	1.0	4.3
Gastro-enteritis & Colitis, under two, 571.0, 764	8	4	4	2.6	2.0	3.0
Cirrhosis of liver, 581	21	17	4	6.9	5.9	9.4
Diseases of pregnancy and childbirth, 640-689	1		1	1.7	6.9	4.9
Congenital malformations, 750-759	21	18	3	3.7	4.4	5.9
Immaturity at birth, 774-776	33	13	20	5.8	4.8	7.6
Accidents, total 800-962	198	136	62	64.9	67.7	66.5
Motor vehicle accidents, 810-835, 960	95	62	33	31.1	40.6	33.4
All Other defined causes	377	238	139	123.5	110.7	129.1
Ill-defined and unknown causes, 780-793, 795	142	65	77	46.5	43.3	41.5

+ late effects

*Rates: Birth and death—per 1,000 population
Infant deaths—per 1,000 live births
Fetal deaths—per 1,000 deliveries
Maternal deaths—per 10,000 deliveries
Deaths from specified causes—per 100,000 population

BUREAU OF PREVENTABLE DISEASES

W. H. Y. Smith, M. D., Director

Current Morbidity Statistics

1968

	Sept.	Oct.	*E. E. Oct.
Tuberculosis	92	110	120
Syphilis	60	61	133
Gonorrhea	422	476	350
Chancroid	6	5	1
Typhoid fever	2	0	2
Undulant fever	1	0	0
Amebic dysentery	0	0	4
Scarlet fever & strep. throat	371	378	125
Diphtheria	10	3	5
Whooping cough	21	8	11
Meningitis	5	3	5
Tularemia	0	0	0
Tetanus	1	0	1
Poliomyelitis	0	0	0
Encephalitis	0	0	0
Smallpox	0	0	0
Measles	0	1	16
Chickenpox	2	3	3
Mumps	8	7	16
Infectious hepatitis	40	39	56
Typhus fever	0	0	0
Malaria	3	0	0
Cancer	824	372	727
Pellagra	0	0	0
Rheumatic fever	7	9	19
Rheumatic heart	8	10	21
Influenza	17	37	31
Pneumonia	146	205	147
Rabies—Human cases	0	0	0
Pos. animal heads	0	3	0

As reported by physicians and including deaths not reported as cases.

*E. E.—The estimated expectancy represents the median incidence of the past nine years.

BUREAU OF LABORATORIES

Thomas S. Hosty, Ph.D., Director

OCTOBER 1968

Examination of Intestinal Parasites	2,313
Examination of Malaria	2
Examination of Salmonella & Shigella (Blood-feces-urine-food)	404
Examination of tubercle bacilli	5,148
Examination for gonococci	1,824
Serological tests for Syphilis	34,501
FTA	112
Darkfield	7
General Bacteriology (cultures for isolation and confirmation)	37
Staphylococcus (cultures for isolation and confirmation)	5
Examinations for diphtheria (cultures for isolation and confirmation)	69
Streptococci examinations	2,653
Mycology	94
Agglutinations	5
Vincent's Infection	20
Complement fixation tests	188
Tests for Phenylketonuria (PKU)	7,493
Cytology	2,631
Water Examinations	3,720
Milk and Dairy Products examinations	5,607
Sea Food Examinations	256
Examinations for Negri bodies (smears and animal inoculations)	391
Virology	12
Rh Factor Bloods	837
Miscellaneous & GC Study	2,624
Total	70,953

Dr. Richardson Hill, Dr. Paul Brann Become Medical College Vice Presidents

Two major administrative changes will be made at the University of Alabama in Birmingham. Dr. S. Richardson Hill, Jr., dean of the Medical College of Alabama, will become vice president for health affairs, and Dr. W. Paul Brann, chief fiscal officer, will be vice president for financial affairs. The announcement was made to the Board of Trustees of the University of Alabama by Dr. Frank A. Rose, president of the University. Dr. Joseph F. Volker, executive vice president, University of Alabama in Birmingham, has been head of the Medical Center since he was appointed vice president for health affairs in 1962. He became vice president of the University of Alabama in Birmingham in 1966, and, as executive vice president, will continue as chief administrator over the entire UAB, which presently includes the Medical Center and the College of General Studies.

"As the University of Alabama in Birmingham continues its remarkable expansion, it becomes increasingly apparent that a full-time administrator is needed for the Medical Center, to assure its continued growth toward logical goals. We are most fortunate to have the highly qualified and capable Dean S. Richardson Hill, Jr., assume this position of leadership. He has demonstrated uncommon abilities as an administrator. His experience as dean of the medical school, and as a key figure in the total development of Medical Center programs, will greatly enhance his effectiveness as vice president for health affairs," Dr. Rose said.

"The Medical Center's growth, in a large measure, has been due to the extraordinary talents and abilities of Dr. Volker, who has led the Center to its present eminence in the health fields. On behalf of the University, I wish to express appreciation to Dr. Volker for his very significant contributions. Under his competent leadership, I am sure the Birmingham campus of the University will develop new and exciting dimensions, and will become, to an even greater extent, one of the nation's leading academic institutions," Dr. Rose said.

Dr. Volker indicated that, by relinquishing his duties as director of the Medical Center, he would be able to devote his energies to the promotion of other areas of the UAB. "We are keenly interested in the growth of this University campus as an outstanding center of higher education in many fields—with excellence in the traditional university programs as well as in more recently conceived activities which relate to the problems and challenges of our present civilization," he said.

As vice president for health affairs, Dr. Hill will direct all activities of the health facilities and schools, with the exception of the baccalaureate programs in the allied health sciences, which are structured as a division of the College of General Studies. The major units responsible to him will be the Medical College, the School of Dentistry, the University of Alabama Hospitals and Clinics, the School of Nursing and the School of Health Services Administration.

Dr. Charles A. McCallum, Jr. is dean of the School of Dentistry; Dr. Florence Hixson is dean of the School of Nursing; Mr. Robert Holters is administrator of University Hospitals and Clinics. A new dean is presently being sought for the School of Health Services Administration. A search committee has been appointed to make recommendations for Dr. Hill's successor as dean of the Medical College.

Dr. Brann has been assistant to the vice president and chief fiscal officer of the University of Alabama in Birmingham since 1962.

"In this capacity, Dr. Brann has reorgani-

zed the University's fiscal structure which is understandably complex and of huge magnitude, and has brought about a smoothly functioning operation. The UAB budget for the coming year will be approximately $45 million; $40 million in construction is currently underway. Managing the fiscal affairs of this institution is a tremendous undertaking, and the responsibilities have multiplied each year. In view of this, we are elevating Dr. Brann to the position of vice president for financial affairs," Dr. Volker said.

Operating under Dr. Brann's direction are the following departments and units: accounting and financial reporting; budgeting; investments; capital financing; property acquisition and management; internal auditing; purchasing; physical plant; personnel services; housing and auxiliary enterprises.

Dr. Brann received his B. A. degree from Arkansas State University; his M. A. and Ph. D. degrees in economics from the University of Virginia. He held the academic appointment of professor of economics at the University of Arkansas, and has held several business administrative positions.

Dr. Hill, a native of North Carolina, is a graduate of Duke University and Bowman Gray School of Medicine of Wake Forest College (1945), where he was a member of Alpha Omega Alpha honorary society.

He served his residency in medicine at Harvard's Peter Bent Brigham Hospital. While at the Brigham, he was a research fellow in medicine at Harvard Medical School, and from 1949-1950, was a Dazian Medical Foundation Research Fellow.

After two years with the U. S. Air Force as chief of Medical Service at Keesler Air Force Base, Mississippi (with the rank of major), he returned to Harvard as an assistant in medicine for one year. He then came to the Medical College of Alabama, in 1954, as assistant professor of medicine and director of the Metabolic and Endocrine Division of the Department of Medicine. He became dean in September, 1962.

The numerous societies of which he is a member include the American Federation for Clinical Research, of which he was a national councilor and president of the Southern Section; the Southern Society for Clinical Research (councilor); the Royal Society of Medicine (fellow); the New York Academy of Science; the American Thyroid Association; the American Association for the Advancement of Science (fellow); the Endocrine Society; and the American College of Physicians (fellow). He has received outstanding alumnus awards from Bowman Gray School of Medicine, 1961; the University of Alabama, 1964 and Wake Forest College, 1966.

Dr. Hill serves on many prestigious regional and national advisory committees, including the Research Career Program Committee (National Institute of Arthritis and Metabolic Diseases); the Veterans Administration—Association of American Medical Colleges Liaison Advisory Subcommittee on Programs for Exchange of Medical Information (chairman, 1967-1971); the Medical Advisory Committee for Social and Rehabilitation Service (1968-1971); the Special Medical Advisory Group, Veterans Administration, Washington (1968-1975); consultant, Bureau of Manpower, Division of Physician Manpower of the Department of Health, Education and Welfare's Public Health Service.

Last year, he served on the Health Sciences Advancement Award Review Panel of the National Institutes of Health and the NIH Pharmacology and Endocrinology Fellowship Review Panel (from 1964-1967).

Medical Groups Honor Alabama Senator On Eve Of Retirement

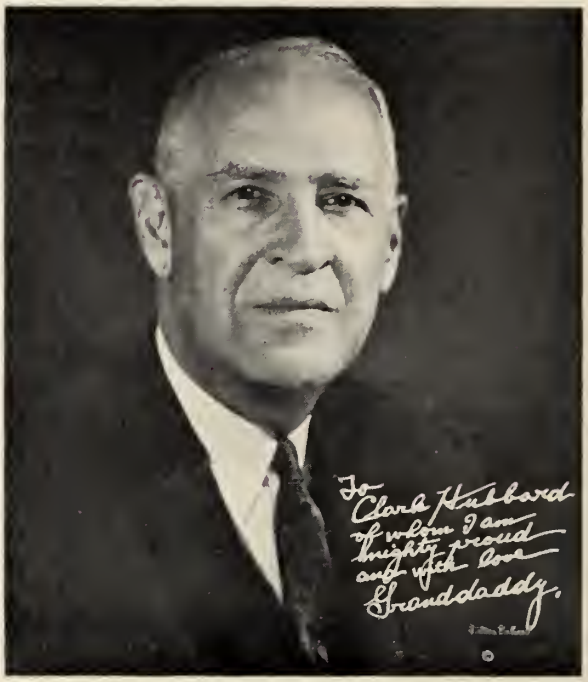
An Alabamian is the first layman to receive an honorary fellowship in the American College of Surgeons for his contribution to medicine since the same recognition was conferred on President Dwight D. Eisenhower in 1957.

The recipient is Alabama's senior senator, Lister Hill, who formally received the award in Atlantic City, on the same program with Charles Wells, Emeritus Professor of Surgery of the University of Liverpool; Norman M. Dott, Emeritus Professor of Neurological Surgery, University of Edinburgh; and Giambattista Bietti, Professor of Ophthalmology of the University of Rome.

The first honorary fellowship awarded by the American College of Surgeons was bestowed in 1913 on the President of the Royal College of Surgeons, Sir Richman Godlee, a nephew of the famed British surgeon, Lord Joseph Lister, for whom Senator Lister Hill was named. Lord Lister was a teacher of the Senator's father, the late Dr. L. L. Hill of Montgomery.

The Alabama Senator has long been recognized as the leader in health in the United States Congress. While Chairman of the Senate Labor and Public Welfare Committee, he guided more than 60 major health measures to enactment. The recipient of 13 honorary degrees from medical colleges and universities throughout the country, he is probably best known as the author of the Hill-Burton Hospital Construction Act and as the leading advocate in Congress of the Federal government's investment in health research and medical and dental education.

Earlier this year, Senator Hill received the American Cancer Society's Distinguished Service Award "for leadership and guidance in the Senate of the United States in support of legislation for the improvement of the health of its citizens." And in November, at the Shamrock Hilton in Houston received the Abraham Flexner Award for Distinguished Service to Medical Education.



Senator Lister Hill

And still a third form of recognition came to Senator Hill on Oct. 21st, when he received a certificate of appreciation from the American College of Radiology for his many contributions to the support of health care.

Calendar of Annual Meetings

Medical Association of the State of Alabama

1969, April 24-26, Carriage Inn, Huntsville

1970, April 30-May 2, Mobile

1971, April 22-24, Birmingham

1972, April 20-22, Montgomery

1973, April 18-21, Mobile

Dr. Clifton K. Meador Becomes Dean Of Medical College

Dr. S. Richardson Hill, Jr., who recently became vice president for health affairs, University of Alabama in Birmingham, has been succeeded in his former position as dean of the Medical College, by Dr. Clifton K. Meador. Dr. Meador, professor of medicine and director of the Clinical Research Center of the College, became a faculty member in 1962.

Born in Selma and reared in Greenville, Ala., Dr. Meador is the second member of his family to become a dean of a University college. His brother, Daniel, is dean of the School of Law on the Tuscaloosa campus.

A graduate of Vanderbilt University (B. A., 1952) and Vanderbilt University School of Medicine (1955), Dr. Meador was a gifted student, with memberships in Phi Beta Kappa and Alpha Omega Alpha medical honorary society. He also received the Walter O. Parmer Scholarship (1948-52) and the Vanderbilt School of Medicine's Founder's Medal for Scholastic Honors.

His internship and residencies in medicine were served at the Presbyterian Hospital, New York, and Vanderbilt University Hospital. He held a fellowship in endocrinology at Vanderbilt Hospital, and served as instructor in medicine at Vanderbilt until entering private practice in Selma, in 1961. A year later, he joined the Medical Center as assistant professor of medicine and assistant program director of the Clinical Research Center.

Dr. Meador was appointed assistant chief-of-staff of University of Alabama Hospitals and Clinics in 1966, a post he relinquished recently.

His outstanding qualifications as a medical academician were recognized by his selection as a John and Mary R. Markle Scholar in Academic Medicine in 1963. This signal honor comes to few young physicians throughout the United States.

Dr. Meador is a member of the American Federation for Clinical Research, the Endocrine Society, the New York Academy of Science and the American Diabetes Association, and is a fellow of the American College of Physicians. His research interests are in the function of the pituitary and adrenal glands, aldosterone action, and body composition in man. He has published extensively in the scientific literature.

In their statement announcing Dr. Meador's appointment, Drs. Volker and Hill said, "Dr. Meador's very considerable ability as an administrator and physician, as well as his excellent relationships with students and faculty alike, make him an immediate and ideal choice as dean of the Medical College. We are extremely fortunate to have an individual of this caliber accept the position as head of the medical school. The great strides already taken by the college will surely be matched or surpassed under his leadership during the coming years. Dr. Meador is a personable and articulate young man who will contribute much to the University, the medical and lay communities and, most importantly, to the academic programs of the school."

Dr. Meador is married to the former Helen Allen of Selma. The Meadors have four children—Clifton Kirkpatrick, Jr., Aubrey Allen, Ann Graham and Elizabeth Garrett.



The Month in Washington

From the Washington Office
American Medical Association

Washington, D. C.—Three-fourths of the medicare Part B carriers now are using individual physician fee profiles in determining reasonable charges.

The Social Security Administration said that these carriers, a total of 36, collectively process 80 per cent of the medicare bills submitted by physicians. Prevailing fees continue as a major factor in the reasonable charges determined by the carriers.

The remaining 14 carriers which have not yet fully developed the individual physician fee profiles, or the computer capacity for using them, are employing other interim techniques. Some use, in addition to prevailing fees, fee schedules; others, relative value scales, or similar techniques, in determining reasonable charges.

The medicare law calls for individual determinations by the carrier which take into account the customary charges of the physician and the prevailing charges in the locality for similar services. In addition, carriers must assure that the charges determined to be reasonable for medicare beneficiaries are not higher than the charges for comparable services under comparable circumstances to their own policyholders and subscribers, according to the SSA.

Payment is to be made on the basis of the lowest of those three criteria, or the physician's actual charge, if that is still lower, the SSA said.

"Making a reasonable charge determination involves checking each bill against compiled data on the individual physician's customary charges for similar services and the prevailing level of charges for such services in the locality in which the physician practices," the SSA said.

"The development of physician fee profiles," according to Thomas M. Tierney, medicare's director, "present a unique challenge to both the SSA and the contracting carriers. At the time of medicare's enactment, there was no industry-wide pattern in the health insurance field on the approach to reasonable charge determination.

"There is evidence now that the successful application of the guidelines interpreting the medicare reasonable charge provisions, including the required development and use of individual physician fee profiles, is leading to a more systematized and consistent approach to the payment of physicians' bills in the health insurance field generally."

The medicare hospital deductible will be increased from $40 to $44 January 1, 1969. The law specifies that if an annual review shows that hospital costs have changed significantly, the hospital deductible amount must be adjusted for the following year. Necessary increases in the deductible amount are to be made in $4 steps to avoid small annual changes.

* * *

The shortage of physicians, particularly general practitioners was cited in a government report as a factor in the increase in physicians' fees since World War II.

The Bureau of Labor Statistics (BLS) reported that charges for medical care, including hospitalization, had risen at an annual rate of 3.9 per cent since World War II while prices of all consumer items combined advanced at a rate of 2.6 per cent per year. The bureau said that medical care prices had risen at a faster rate in recent years, 6.6 per cent in 1966 and 6.4 per cent in 1967.

The report said that physicians' fees, while

not advancing as rapidly as hospital charges, had more than doubled in the past 10 years. Hospital charges more than quadrupled.

"The rise in physicians' fees during the 1946-67 period is partially due to the general rise in price levels and to the physicians' need for increased income to cover his personal and business costs," the report said.

"This is especially true for the past two years. Doctors have tended to attribute their higher fees in recent years to the general economic conditions and the higher cost of doing business. Nevertheless, some charges clearly reflect the shortage of doctors. With an overload of patients, physicians in some cases have tried to discourage the practice of making house calls by raising the rate for such a service to a level that few patients are willing to pay. The postwar emphasis on medical specialists has also helped to boost physicians' fees since general practitioners have become scarce and specialists, with their extra training, are able to command higher fees."

The number of GP's declined from 73,593 in 1963 to 68,920 in 1967 while the number of physicians in all categories was increasing from 276,475 to 308,475.

The BLS conceded that its reports on health care costs do not give adequate consideration to improvements in the quality of medical care as reflected in longer life spans, improved and more efficient techniques for treatment, shorter hospital stays, etc.

"It is obvious that there are many problems of definition and measurement to be solved before any progress can be made in introducing appropriate methods of measuring medical care price changes in a more meaningful way," the report said.

Two other federal developments dealt with medical care for the poor. The Board of Medicine of the National Academy of Sciences announced start of a comprehensive, two-year study titled "Health and the Poor." A joint state-federal task force reported on its study of costs for medical and public assistance programs.

The Board of Medicine named a special panel for its study which will cover: the quantity and quality of medical care the poor now receive; existing federal programs, such as medicaid, anti-poverty projects, maternal and child health programs, and community immunization programs; future needs and possible programs; and the economics of medical care for the poor.

Recommendations of the joint task force to the Department of Health, Education and Welfare included:

—States should draw samples to produce information on the current utilization of each of the medical care services offered, and their costs. The sample should provide data on how much of these costs are borne by the medical assistance program, and the amount that comes from other sources.

* * *

President Johnson signed into law a bill providing for tougher penalties for illegal traffic in amphetamines and barbiturates. LSD also is covered specifically.

The new law makes illegal possession, manufacture or disposal of the drugs a misdemeanor carrying maximum penalties ranging from imprisonment of one year and a fine of $1,000 to imprisonment of 15 years and a fine of $20,000. Leniency is authorized for first offenders.

Johnson praised the law as a measure that will "strengthen the hands of our police and give our families protection." He said it should "put the drug peddler in jail." But, he added, the active support of all Americans —both adults and young—is needed.

* * *

Richard M. Nixon will take over as President pledged to oppose national compulsory health insurance and federal control of physicians' fees. Highlights of his position on health care issues:—

(Continued on Next Page)

Federal Role in Medicine

The role of the federal government in medicine should be supportive, never dominating. It should serve as a catalyst and supplement private efforts only as needed.

Medicare

Although the program has been plagued by financial and administrative problems, it offers good potential if wisely administered.

Medicare must provide needed services at the lowest possible cost. The program could be endangered by a continuing escalation of costs.

More effort is needed to reduce dependence on costly hospitalization through better use of extended care facilities and increased use of outpatient care. Also needed is a reexamination of reimbursement formulas and experimentation with financial incentives to assure that the program encourages efficiency at all levels.

Medicaid

I favor the basic philosophy of medicaid—that of helping medical indigents who need aid to meet medical expenses. Unfortunately, the program has fallen short of its expectations. . . .

What is needed is a careful reassessment of medicaid, especially at the local level, with full professional guidance, and emphasis on advice from physicians. There also is a need for simplification of literature and application forms.

National Compulsory Health Insurance

I oppose a national compulsory health insurance program because I do not want to lower the quality of medical care in the United States. Also, new health programs should be geared only to persons in need . . . .

I want to see that every individual who needs medical care is able to get it. But I want it to be good medical care. That's why I want to keep the doctors free from government control as much as possible and oppose extension to a national compulsory health insurance program for everyone.

Compulsory Areawide Health Planning

I oppose compulsory areawide health planning. We can't assure communities better health planning just by making such groups compulsory. Areawide planning should be left to state and local determination.

Federal Control of Physicians' Fees

I oppose federal control of physicians' fees. Our system is an open, competitive market, assuring an individual the prerogative of setting a value on the services he performs. I would be as opposed to infringing on this right by regulation of physicians' fees as I would be to regulating fees charged by the members of any other profession.

Department of Health

As President, I intend to establish a Commission on Government Reorganization to study thoroughly ways of increasing efficiency in government organization as well as making it more responsive to the people.

Mental Health

We must develop new methods of treating the mentally ill. . . .

Tax Deductions for the Aged

The 100 per cent income tax deduction for non-reimbursable drug and medical expenses of those over 65 should be restored.

Preventive Medicine

Preventive medicine is, in my judgment, both an opportunity and a major challenge to medicine.

Automated mass screening programs would

seem to have great possibilities even though they are generally still in their infancy and therefore cannot yet be gauged concerning their effectiveness in preventing chronic illness and reducing deaths. Information about these programs is still inadequate to warrant a broad federal program.

Hill-Burton Act

As demand for hospital facilities increases, additional funds under the Hill-Burton Act for construction and modernization of such facilities will be required to supplement state and local efforts.

To assure the most efficient use and distribution of Hill-Burton funds, a proposal for bloc grants in this area should be considered.

Abortion Laws

Nothing should be done on the federal level. The abortion laws should be considered by each state, and should be acted upon by each state, depending upon the opinion in that state. . . . I do not think that a nationally-imposed law would be one which would be accepted in many parts of the country, and only when a state—a majority of people of the state—reach a conclusion that they want that kind of legislation, as they did in Colorado and as they may in the state of New York, should such a law be passed or considered.

Although drinking is no longer taboo on a growing number of campuses, alcohol education has failed to keep pace with the relaxed rules against it, Dr. Jack Mendelson, chief of the National Center for Prevention and Control of Alcoholism, National Institute of Mental Health, reports. Noting that "60 per cent of teenagers today drink before leaving high school," Dr. Mendelson insists that "Education should meet the needs of young people."

New Type Otoscope Devised By California Otolaryngologist

Adapting the concave-glass principle of the head-mirror for light, a California doctor has invented a new type otoscope that eliminates the bad features of the standard one—notably parallax error, insufficient light, clumsiness, and the spout-like speculum that often hurts sensitive ears.

The Hotchkiss Otoscope, with coaxial lighting, around-the-neck power supply, combining the advantages of the head mirror without the need to learn how to manipulate it, requires no adjustment. The optical head weighs only 2¼ ounces and it measures 4¾ inches from eye piece to speculum tip.

Dr. John E. Hotchkiss, the inventor, is a youthful 44. With San Francisco colleagues he founded Hotchkiss Instruments in February, 1968; the firm contracts with some 30 to 40 vendors for parts, and the otoscope is assembled by personnel at the San Francisco Rehabilitation Workshop, providing occupational therapy for the handicapped.

The unit includes optical head, six flanged specula, pneumoscopy bellows and "around the neck" battery supply. The optical head may be powered by AC transformer or battery power supplies, with interchangeable use of conventional or rechargeable batteries.

Outside the United States it is being marketed by Smith, Kline and French Laboratories.

Calendar of Annual Meetings

Medical Association of the State of Alabama

1969, April 24-26, Carriage Inn, Huntsville

1970, April 30-May 2, Mobile

1971, April 22-24, Birmingham

1972, April 20-22, Montgomery

1973, April 18-21, Mobile

"New Concepts In Viral Diseases" Continuing Education Subject

A one-day course in Viral Diseases in January and a two-day course in Obstetrics-Gynecology in February, have been scheduled, Dr. Margaret S. Klapper, associate dean and director, Division of Continuing Medical Education, announces.

Details of the latter course, to be held Feb. 13-14, with Dr. Edwin G. Waldrop as course director, have yet to be completed. However the Registration fee will be $30.

"New Concepts in Viral Diseases" is the general subject of the one-day course scheduled for Thursday, Jan. 16th, with Dr. Charles Alford, Jr., Meyer Research Professor of Pediatrics, as course director.

Dr. John W. Benton, Jr., associate professor and acting chairman, Department of Pediatrics, is chairman for the morning session, which begins at 9 o'clock, and opening remarks will be made by Dr. R. Burt Prater, Jr., acting chief, Seminar Services Unit, National Communicable Diseases Center, Atlanta. The group will be welcomed by Dr. S. Richardson Hill, Jr., professor of medicine and vice president for health affairs, and by Dr. Klapper.

"Advances in Virology" will be the subject of Dr. Maurice A. Mufson, assistant professor of medicine, University of Illinois College of Medicine, and director of Virology, Hektone Institute for Medical Research for the Cook County Hospital, Chicago, followed by Dr. Max Dale Cooper, professor of pediatrics and associate professor of Microbiology, on "Immunology and Vaccine Development in Viral Diseases."

Dr. Frederick W. Dinehardt, chairman, Department of Microbiology, Presbyterian-St. Luke's Hospital, Chicago, and professor, Department of Microbiology, Medical and Graduate School, University of Illinois, Chicago, has as his subject, "Hepatitis and Comments on Gammaglobulin," while "Viral Diagnostic Studies Available in Alabama" will be the subject of Drs. Robert D. Francis, associate professor of Microbiology, and consultant, State Health Department, and Thomas S. Hosty, clinical associate professor of Public Health and Epidemiology, and director, Bureau of Laboratories, Department of Public Health, Montgomery.

After lunch, Dr. T. Joseph Reeves, professor and chairman, Department of Medicine, and director, Cardiovascular Research and Training Center, will preside as chairman of the afternoon session, which will be opened with Dr. Charles A. Alford, Jr., Meyer research professor of Pediatrics, speaking on "Chronic Congenital Infection of Man," followed by Dr. Bernard Fields, associate in Medicine and Cell Biology, Albert Einstein College of Medicine, New York City, whose subject is "Changing Trends in Viral CNS Disease."

Dr. Clarence J. Gibbs, chief, Laboratory of Slow Latent and Temperate Viruses, National Institute of Neurological Diseases and Blindness, National Institutes of Health, Bethesda, Md., has as his subject "Current Concepts of the Role of Slow Viruses in Disease," and a concluding feature will be a panel discussion, "Interferon and Other Antiviral Agents," with a question-and-answer session open to the audience. Dr. Alford will be moderator and panelists are Drs. Cooper, Dinehardt, Fields, Francis, Gibbs, Hosty, and Mufson.

Humanitarian Service Certificate Awarded Dr. Joanne Smith T



From left: Dr. Orizaba Emfinger, Mrs. Winston Smith T, Mr. Smith T, and Dr. E. L. McCafferty, Jr., president of the Medical Association of the State of Alabama. In the background is the bust of Dr. Jerome Cochran, elected Alabama's first health officer in 1879.

A "Certificate of Humanitarian Service," awarded by the American Medical Association to Joanne Smith T, M. D., was presented in absentia to her parents at the November meeting of the Board of Trustees of the Medical Association of the State of Alabama.

The certificate was awarded "in recognition of meritorious service performed for the Medical Profession, the United States Government, and the People of South Vietnam, by treating the ill and injured during a medical mission under AMA's Volunteer Physicians of Vietnam." The certificate was signed by Wilfred O. Rouse as AMA president.

Dr. Smith T has returned to Vietnam to continue her tour of duty, after completing her residency training at Grady Memorial Hospital in Atlanta. She is presently in Saigon, though her earlier duty had been 600 miles to the north, in DaNang, the second largest city in South Vietnam.

Making the presentation to Mr. and Mrs. Winston Smith T, of Opelika, was Dr. Orizaba Emfinger of Union Springs.

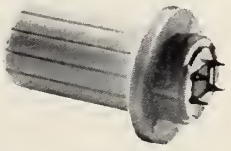


Dr. Joanne Smith T with one of her Vietnamese patients.

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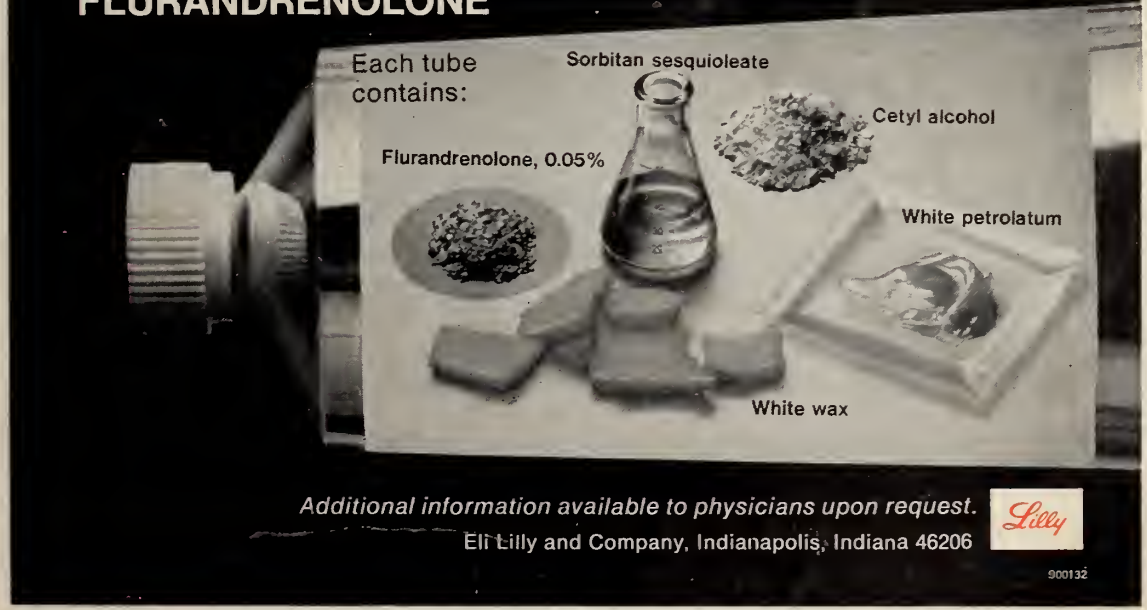
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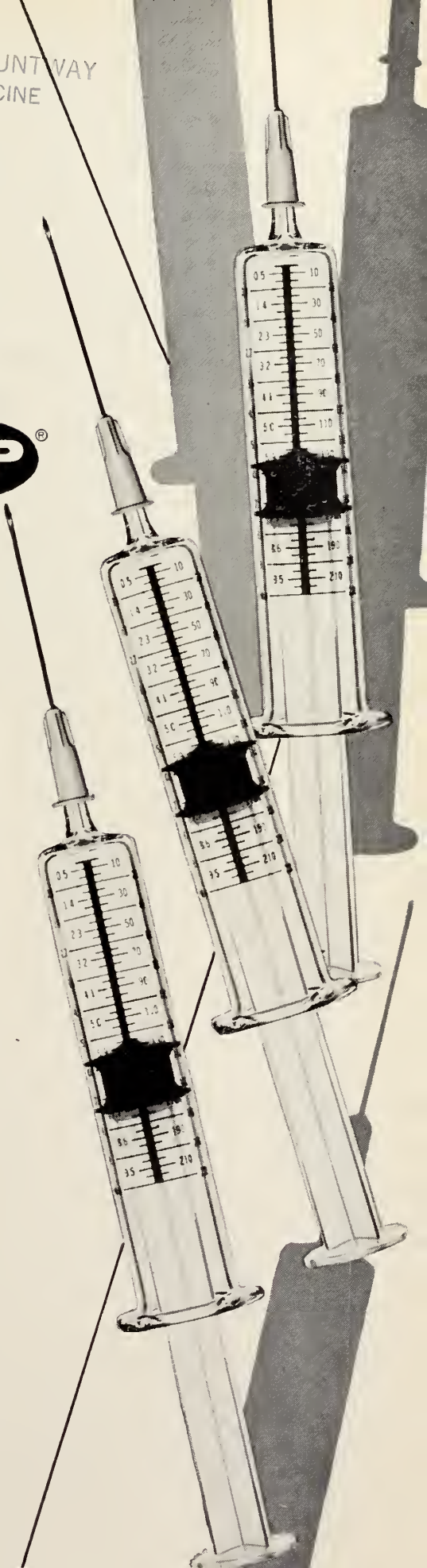
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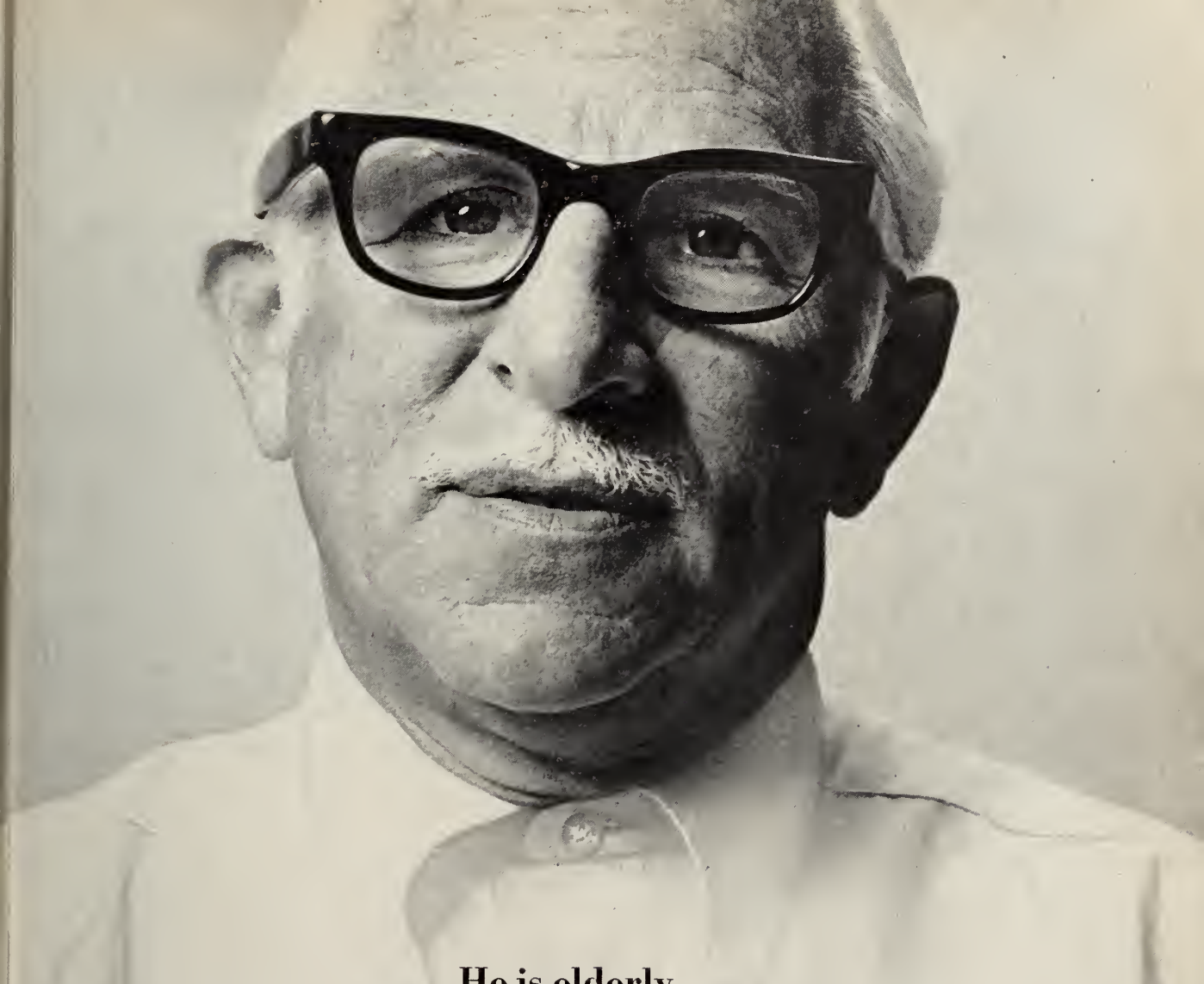
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President's Page



E. L. McCafferty, Jr.

On Sunday (November 24, 1968) the Alabama Hospital-Medical Council met in Montgomery and discussed areas of mutual interest and pledged a united effort to work toward solving potential problems that can arise between medical staffs, administrators and boards of trustees.

This is not a new committee but could, in my opinion, be most influential in strengthening the bonds of cooperation among the members of the health team. We have also in recent months assigned to the Medical Association component of Alabama Hospital-Medical Council the responsibilities of liaison with the State Nurses' Association.

Since we as a team are mutually dependent upon each other, it behooves each association to work toward the formation of a smooth functioning unit if we are to practice our profession to the greatest extent of our individual abilities and to the maximum benefit of our patients' welfare. Although these three associations are the largest individual groups, it is equally necessary that we work with and coordinate our efforts with the other ancillary services that contribute such an important part in the care of a patient and towards their ultimate recovery.

This committee composed of representatives from the Hospital Association and the MASA are knowledgeable men with a desire to bring to the State of Alabama the ability "To mobilize all the positive forces for healing and good will and to get the most out of human creativity" on a combined level.

This goal indeed brings to the medical profession a concept whereby we should look more closely at our responsibilities as a profession and be less sensitive as to our rights as individuals.

Over the past few years the federal government has imposed itself on the medical profession to such a degree that when we discuss the future of medicine we consciously or unconsciously add the government factor of participation and instinctively wonder to what extent the medical profession will be influenced by social forces outside of our command. In an effort to preserve private practice as we know it the profession in Alabama has usually resisted change and on the whole has not participated enthusiastically in the numerous government programs in their formative stage, and in certain instances has opposed these programs on the grounds that our private rights are being imposed upon. Certainly I am not suggesting that the profession has not acted without justification or the support of the majority of the individual physician or that the final chapter has been written regarding the ultimate value of all of these programs but I do think that the time has come to us as an organized group to reevaluate these programs in the light of our responsibilities rather than in the simple guidelines of our personal rights.

It seems to me that this approach will offer to us as individuals a look at both sides of the great problems that face our country in the years ahead and will give to our profession an approach that will elevate the profession in our own eyes and in the hearts of our patients.

This approach of responsibility to me seems easy to accept since all of us have entered the practice of medicine and continue as its disciples because of the satisfaction we derive from the respect of our patients and the spiritual rewards of returning a sick person to health and a responsible position in society. The problem as I see it is fundamentally one of degree, and it is to this end that we, as doctors in Alabama, should direct our interest and attempt to provide those services that people need and at the same time retain the individual freedoms of the profession that make our calling in life so satisfying.

Following the recent presidential elections it has been widely assumed that the next Congress and Administration will be more conservative in its approach to overall operation of the federal government, and it is hoped that a balance of restraint will be exhibited by the government between those services that are necessary and those that unnecessarily deprive us of our individual freedoms.

The reactivation of the Alabama Hospital-Medical Council offers an opportunity to the Medical and Hospital Associations to improve its response on a local level to the needs of our patients and to render a more effective service to the community.

It is hoped that the medical staffs, the administrators, and the board of trustees will assume this responsibility and acting together will create an environment in which each of us can contribute our maximum efforts.

E. L. McCafferty Jr.

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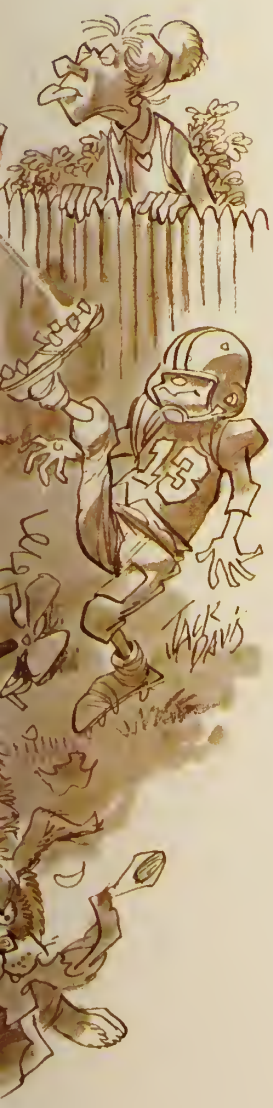
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WARNINGS: May be habit forming. Dosage of coumarin anticoagulants may require adjustments during and on cessation of therapy.
Use in Pregnancy
Safe use in pregnant women, or during lactation, has not been established. Therefore, benefits must be weighed against potential hazards.
PRECAUTIONS: Periodic CBC is advised during prolonged therapy.
ADVERSE REACTIONS: Side effects are rare. Nausea, transitory dizziness, anuria, and rash may occur. Overdosage of allobarbital will produce symptoms of barbiturate excess.
DOSAGE AND ADMINISTRATION
Adults: One or 2 tablets q 4 h, not to exceed 8 tablets in 24 hours.
Children 6 to 12: One-half to one tablet q 4 h, not to exceed 4 tablets in 24 hours.
SUPPLIED: Tablets (white, scored), each containing 15 mg allobarbital and 300 mg acetaminophen; units of 3 bottles of 30.

Consult complete literature before prescribing.

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(allobarbital and acetaminophen)

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WAMASA Editor, Mrs. William L. Smith

AUXILIARY PLEDGE

"I pledge my loyalty and devotion to the Woman's Auxiliary to the American Medical Association. I will support its activities, protect its reputation and ever sustain its high ideals."

Since writing my last President's Page, I have been travelling far and wide in the interest of the Auxiliary, and have had many rewarding experiences.

The month of November began with a luncheon, as guest of the Birmingham-Jefferson Auxiliary. The speaker was Dr. William Daniel, who recently returned from a tour on the good ship "Hope." He showed slides of some of his experiences and made us realize the tremendous good that is being done through "Project Hope."

The Northwest District meeting was held on November 6 in Decatur, with Mrs. Gene Qualls presiding. The Luncheon speaker was Reverend Benjamin Smith, Chaplain of the Medical School, Birmingham, whose subject was "How to be a Person as well as a Doctor's Wife." His message was thought-provoking and unusual.

On November 12, I attended the meeting of the Mobile Auxiliary at General Hospital, Mobile. Before lunch, we had the opportunity of hearing a lecture and seeing a film on Heart Catheterization, which was most interesting and informative.

I was in Florala on November 13, speaking to the members of the Covington County Auxiliary. On the following day, I attended the Northeast District Workshop in Centre, with Mrs. Eugene Bradley presiding. This, too, was a fine workshop, and very profitable to all who attended.

During November, I had the pleasure of attending a Health Careers Breakfast in Montgomery, and the Southern Medical Auxiliary meeting in New Orleans, November 17-19. The business sessions were informative, and the social activities, planned with real Southern hospitality, were most enjoyable. Mrs. Virgil Forrester, Oklahoma, was installed as the new President.



Mrs. Robert K. Wilson, Sr.

As I look back on this busy month, I realize it has been very pleasant and inspirational, and I am grateful for each experience.

Speaking of being grateful, I am writing this during the Thanksgiving season, and as I have been driving from one end of the state to the other, I have realized anew the beauty of our state, and how much we have to be thankful for, as citizens of the United States and Alabama, and for the opportunity

of serving our fellow man. It is my earnest prayer that we will not take our blessings for granted, and that we shall ever strive to be more worthy of them.

Louise M. Wilson

(Mrs. Robert K. Wilson, Sr.)
President WAMASA

Books Of Professional Interest

MAN'S RISE TO CIVILIZATION (As Shown by the Indians of North America from Primeval Times to the Coming of the Industrial State), by Peter Farb, E. P. Dutton, New York, 352 pages, illustrated with photographs, maps and charts—$8.95.

This Book-of-the-Month Club selection is one of the more important books of this decade, with a dual appeal to the romantic and the intellectual. Or, to quote from the foreword by Prof. Elman R. Service, Professor of Anthropology, University of Michigan: "It is the best general book about North American Indians that I have ever read and it also does a fine job of illustrating an important use of cultural evolutionary theory."

Although there is a complete lack of human skeleton remains, we know from projectile points and other artifacts that some sort of human being peopled this continent thousands of years before Christ. And from there to today, Peter Farb traces our evolving culture with equally fascinating text and pictures. This, by the way, is the second Book-of-the-Month Club selection to carry his byline. The first was "Face of North America."

One may freely predict that the discoveries presently being unearthed by David Chase, director of the Montgomery Museum of Fine Arts, will add further to the knowledge of early man on this continent, as detailed in Farb's book.

SO HUMAN AN ANIMAL, by Rene Dubos, Charles Scribner's Sons, New York, 283 pages—$6.95.

An advance-of-publication critic tags this book "a wide-ranging book by one of the most distinguished pioneers in the new science of microbiology. Because he is almost as much at home in philosophy and literature as in his specialty, he can relate, as few others can, the 'two cultures.' I have read no other book which so clearly explains why science is indispensable but not omnicompetent."

Dr. Dubos, a native Frenchman, a naturalized American, professor at The Rockefeller University, New York City, is a microbiologist and experimental pathologist who over 20 years ago was the first to demonstrate the feasibility of obtaining germ-fighting drugs from microbes. He is author of five earlier published books, including "Louis Pasteur—Free Lance of Science" and "The Mirage of Health."

"So Human An Animal," explaining how we are shaped by surroundings and events, is timely, eloquent, and "guided by a deeply humanistic spirit." Dr. Dubos sets the pace early in his book with the observation: "This society has more comfort, safety, and power than any before it, but the quality of life is cheapened by the physical and emotional junk heap we have created."

—W. J. M., Jr.

Calendar of Annual Meetings

Medical Association of the State of Alabama

1969, April 24-26, Carriage Inn, Huntsville

1970, April 30-May 2, Mobile

1971, April 22-24, Birmingham

1972, April 20-22, Montgomery

1973, April 18-21, Mobile



Summation:
In addition to its primary indications for duodenal and gastric ulcer, Robinul Forte (glycopyrrolate) is indicated for other G-I conditions that may benefit from anticholinergic therapy. Robinul-PH Forte (glycopyrrolate 2 mg. with phenobarbital) is indicated when these situations are complicated by mild anxiety and tension.

Contraindications: Glaucoma, urinary bladder neck obstruction, pyloric obstruction, stenosis with significant gastric retention, prostatic hypertrophy, duodenal obstruction, cardiospasm (megaesophagus), and achalasia of the esophagus, and in the case of Robinul-PH Forte, sensitivity to phenobarbital.

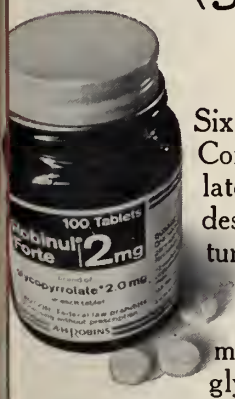
Precautions: Administer with caution in the presence of incipient glaucoma.

Adverse Reactions: Dryness of the mouth, blurred vision, urinary difficulties, and constipation are rarely troublesome and may generally be controlled by reduction of dosage. Other side effects associated with the use of anticholinergic drugs include tachycardia, palpitation, dilatation of the pupil, increased ocular tension, weakness, nausea, vomiting, headache, dizziness, drowsiness, and rash.

Dosage: Should be adjusted according to individual patient response. Average and maximum recommended dose is 1 tablet three times a day; in the a.m., early p.m., and at bedtime. See product literature for full prescribing information.
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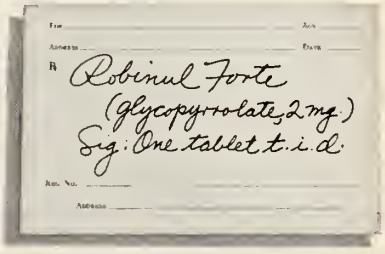
In peptic ulcer therapy, won't you give Robinul® Forte a Fair Trial?
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Six years ago the A. H. Robins Company introduced glycopyrrolate, a unique anticholinergic agent described in the prescribing literature as more closely approaching the ideal compound for controlling gastric hyperacidity and hypermotility of the G-I tract. Although glycopyrrolate (Robinul Forte) found good acceptance among numerous physicians, many others just didn't seem to want to give it a try, probably because the anticholinergic they were already using was giving acceptable results.

However, we believe you'll agree there's always room for a better anticholinergic. This is why we're asking you to give Robinul Forte a fair trial. Robinul Forte exerts a highly specific antisecretory action and marked inhibitory effect on intestinal tone. We're convinced you'll agree that this is indeed an outstanding drug when you observe its outstanding suppression of ulcer symptoms. Furthermore, it is unique in that it reduces intestinal tone, yet has little or no effect on peristalsis. In addition, the incidence of the more bothersome peripheral side effects is low.

No longer does the physician have to look for extreme dry mouth as the measure of his anticholinergic's effectiveness. The only way we can demonstrate to you firsthand the efficacy of glycopyrrolate (Robinul Forte) is for you to try it in your practice. That's why we're asking you to give it a Fair Trial. How can you give it a Fair Trial? You do it this way:



First: When you see your very next ulcer patient, write him a script as shown.

Next: Wait 10 days or until your patient comes in for his next appointment and get his "verdict" as to how he feels. Examine all the evidence and make your evaluation of his condition.



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The summation is an important part of every case. You'll find ours on the preceding page, Doctor.



Editorial COMMENT

Wassail! . . . Good Health, Happiness, Prosperity

January is the month of good intentions. It comes in with the lion-like determination of New Year's Resolutions and generally goes out like the Cowardly Lion of the Wizard of Oz, carting off those same shattered resolves.

It was named for the two-faced Roman god Janus.

Jan. 1st is quite young as a holiday in English-speaking countries. It was under 25 years old when the United States became a nation. Before 1752, when England and her American colonies adopted the Gregorian calendar, the New Year was celebrated on March 25th.

Whenever it was celebrated, however, it remains man's oldest holiday. And it is significant—especially to doctors—that the ancient Anglo-Saxons celebrated the New Year by drinking Wassail. The word itself means "to be hale, to be hearty, to be whole."

January has been the birth month of many notables. And the first of January is the birthday of two people famous in American history—Betsy Ross and Paul Revere. It is the birthday (1484) of Zwingli, the great Swiss religious reformer, and (1431) of Rodrigo Borgia, destined to become notorious as Pope Alexander VI.

A knowledge of history is a wonderful thing, for yesterday is important to all of us. It is our memory, our nostalgia, the years past, glossed over by wishful thinking.

But it is today and tomorrow that concern us most—another year, another milestone.

And in this January issue of the *Journal of the Medical Association of the State of Alabama,* it is appropriate to wish every member of MASA and his family: *Wassail!* Good health, happiness and prosperity.

Some Like It Hot, Some Like It Cold . . . But Most Like Both!

Some senior citizens of the medical profession may remember back to the day when medical opinion was split into two rival camps, those favoring heat for treatment and those protesting that the only correct therapy was cold.

Today we distinguish them as cryotherapy and thermotherapy.

In medical dictionaries generally one will find three times as many entries stemming from the basic word "therm" (for heat) as from the stem word "cryo" (for cold). And in addition there is generally a table of Centigrade and Fahrenheit equivalents, sandwiched between the heat entries.

But in the 60-odd "therms" in the dictionary, there is no thermosurgery.

One may be very sure, on the contrary, that heat sterilized the instruments used in cryosurgery, and that body heat is one of the vital factors to be watched in any use of the

scalpel, from an appendectomy to a heart transplant.

So the once warring methods are now married, and the world's general health is further benefited by the union.

The Society of Cryosurgery, meantime, has scheduled its annual meeting at the Hilton Plaza, Miami Beach, for the week beginning Sunday, Jan. 12th, with the nine divisions of the society planning programs.

The nine are: Cryo-Ophthalmology and Cryo-Orolaryngology, Cryo-Neurosurgery and Cryosurgery of Tumors, Cryo-Urology and Cryo-Gynecology, Cryotherapy of Skin Diseases, Cryobiology, Cryo-Engineering and Cryo-Instrumentation.

Returning to the combination of heat and cold, one recalls the observation of John, Viscount Morley, made a hundred years ago: "Where it is a duty to worship the sun, it is pretty sure to be a crime to examine the laws of heat."

We've come an even longer way in bridging whatever medical gap may exist between heat and cold, for the ultimate good of humanity.

Civilized Man Must Shoulder His Responsibility to Survive

"Responsibility is more than just a desirable phenomenon, it is a biological necessity," Dr. Jonas Salk, who developed the first polio vaccine, told the National Conference of Editorial Writers.

Then he proceeded to explain the irresponsibility of juvenile elements in our society, but not to excuse it.

Once, he said, a father knew more than his son and a grandfather knew more than the father. The order is now reversed, "so overwhelming is the knowledge explosion, thereby contributing to the sense of unsettlement in society."

The generation gap in a sense reflects a difference in purpose in the lives of young people and their elders, with some young people finding purpose enough in rebelliousness itself, rather than in accomplishment. "Values, sense of purpose, and responsibility are all interrelated," he added.

Using molecular structure as an analogy, Dr. Salk said that each unit in a cell must behave reliably. "Whenever one behaves irresponsibly, derangements and disorders occur. Each individual in society has an obligation to behave responsibly."

There is a hierarchy of responsibility, he continued. "For his own self-dignity and lust for life, each individual should be left with as large a responsibility as he is able to assume. Governments are established to fix limits of responsibility, to protect the individual."

He saw demogogues and dictators as reflecting an exercise in exaggerated responsibility, adding that "They are made by the abdication of responsibility by many, its assumption by fewer, and eventually by one."

He said that the world must avail itself of existing knowledge, and there "must be a three-fold exercise of responsibility: Public and professional responsibility (of governments and doctors) to make the benefits of knowledge available; and personal responsibility of the individual to avail himself of it."

Where mankind goes from here, Dr. Salk concluded, "depends on how well man accepts his responsibility as trustee of his own evolution."

The Sex-Knowledge Gap Between Adults And Children

How to describe "the man act" and its attendant conception, development and birth, has been the concern of many an articulate person, lay and professional, since the veneer of civilization first covered the primitive facts of life in the name of religion, good taste and self-restraint.

Dr. Morris Fishbein, who was for 27 years the editor of the *Journal of the American Medical Association*, author of more than 40 books on medical subjects, and Dr. Ner Littner, director of the Child Therapy Training Program, Chicago Institute for Psychoanalysis, contribute paralleling introductions to and in praise of a picture book for young people, just published by a Chicago house.

Dr. Fishbein says the author, Arthur Shay, has provided in his book "the right sexual bridge between adult and child," using "his own magic blend of warm photography and sensitive, whimsical but never crude writing."

How A Family Grows is the book's title, the publisher Reilly & Lee.

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Computer Industry

The computer industry seems destined to become one of the largest industries in the world within the next ten to 15 years. Its growth to date has been very impressive, but I feel its growth in the future promises to be more dramatic.

Many observers predict that the industry can more than double in size in the next several years. Certain segments of the industry may grow at a more rapid pace. The value of computer industry shipments, including peripheral equipment software and supplies totaled $300-$400 million in 1955 and grew to more than $6½ billion in 1966. In Merrill Lynch's opinion, shipments could reach an annual rate of $15 billion by 1975. And even this forecast could prove to be conservative.

I feel that Leasco Data Processing (although still a relatively young company) has already established itself as a major factor in the leasing and software segments of the computer industry, and recently became an important factor in the fire and casualty insurance business through the acquisition of Reliance Insurance. In addition, it has entered the dynamic field of time-sharing and has expanded into the promising container leasing area. From the very small lessor of a few years ago, Leasco has now grown into a diversified firm with estimated assets of close to $1 billion and net worth of over $300 million. Perhaps its most important asset is an aggressive and capable management team, which has been strengthened in recent months by the addition of experienced personnel in both the computer and financial fields.

For the September 1968 fiscal year, Merrill Lynch estimates fully diluted earnings per share at about $4.60 compared with the proforma $4.09 of fiscal 1967. Prospects for fiscal 1969 are excellent, in our opinion. Aided by more aggressive management of Reliance's relatively conservative investment portfolio, continuing growth in computer leasing, although probably at a somewhat slower pace, and significant gains in computer software and container leasing, earnings are projected in the area of $7.50-$8.00 per share on a fully diluted basis, excluding possible acquisitions. We expect the gain in profits to be almost equally derived from insurance and non-insurance operations. In fact, earnings from computer leasing, software services, and container leasing will probably increase from over 20 percent of our fiscal 1968 estimate to more than 30 percent of our fiscal 1969 estimate. Both estimates include a moderate amount of capital gains from Reliance's investment portfolio in line with Leasco's intention of reporting such gains as part of net income.

In our opinion, Leasco's acquisition of Reliance Insurance may be only the first of several steps into the financial services area. With its broad capabilities in the computer field playing an important role, Leasco plans primarily through acquisitions to become a major integrated financial services concern both on the industrial and consumer levels. On the computer front, management's goal is to increase software volume from the current annual rate of $40 million to $100 million partly through acquiring a major consultant firm. Aggressive expansion is planned in

The information set forth herein was obtained from sources which we believe reliable, but we do not guarantee its accuracy. Neither the information, nor any opinion expressed, constitutes a solicitation by us of the purchase or sale of any securities or commodities.

time-sharing and European computer operations. Leasing of peripheral equipment may gradually account for an increasingly larger portion of computer leasing business. Container Leasing will also be expanded. Possible entry into the production of computer hardware is still under study by management but the outcome cannot be predicted as yet.

Because a major portion of Leasco's earnings are now derived from its insurance operations, the stock may not command the very liberal PE ratio of recent years. However, we believe these speculative shares selling around 131 (at the time of this writing) and about 17 times projected earnings for fiscal 1969 are attractively priced and offer above average appeal for medium and long term appreciation.

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BRIEFS

Dr. John E. Steinhaus, professor and chairman of the Department of Anesthesiology, Emory University School of Medicine, has been elected president-elect of the American Society of Anesthesiologists, to assume the presidency in October, 1969. With a B. A. and M. A. from the University of Nebraska, h's M. D. and Ph. D. from the University of Wisconsin, Dr. Steinhaus went to Emory as an assistant professor in 1958, became professor and chairman of anesthesiology in 1959, was elected president of the Greater Atlanta Society of Anesthesiologists in 1960, and has held important positions in the professional organization since.

* * *

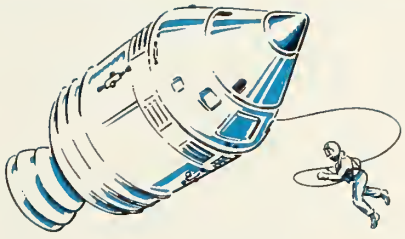
The Society of Cryosurgery will hold its annual meeting at the Hilton Plaza, Miami Beach, Jan. 12-17, and all physicians and surgeons who wish to attend are invited to do so. Out-of-the-country members who will participate as chairmen or moderators include: Profs. G. Bietti, Rome; T. Krwawicz, Poland; J. Barraquer, Bogota, Colombia; W. Brinkman, Holland; F. Sesia, Italy.

* * *

Changing patterns of pediatric practice were discussed in Evanston, Ill., at a regional meeting on child health, held by the American Academy of Pediatrics. These and a comprehensive education program to interpret them were hailed as two major challenges confronting today's pediatricians.

* * *

"Why Wait?" programs are sprouting up all over the country. In its first year, Peoria, Ill., found 218 residents who have diabetes and didn't know it, plus another 69 who are borderline diabetics. Because of its success, Peoria leaders have decided to extend their activities for at least another year.



Man in space, now fait accompli, re-emphasizes the importance of Uro-Phosphate therapy. Research into the effect of space travel on the astronaut reveals that weightlessness causes loss of bone calcium. As the bones are required to bear less and less of the weight of the body they lose calcium, increasing the calcium content of the urine. When physical activity is reduced, the acidity of the urine should be adjusted to keep increased calcium in solution . . . . a prophylaxis to prevent kidney or bladder calculi.

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Legal Death---Can It Be Defined?

Reginald T. Hamner, LL. B.

Director, Legal-Legislative Affairs

The Medical Association of the State of Alabama

The legal profession has neither the knowledge nor the technology to establish a precise "time of death"; however, death is an important concept upon which many legal rights turn. The will of the testator does not become effective until his death. Rights of survivorship frequently involve the determination of who survived whom when the parties have sustained fatal injuries in a common circumstance.

Inherent in the question of "time of death," is the necessity to establish an agreement as to what constitutes death. Though the legal definition of death is important for determining legal rights, law defines death not by some dictionary criteria but by scientific criteria used by physicians and accepted by the public. This is a determination for the medical profession. When seeking to establish a workable meaning of death in the past, not only have the professions of medicine and law been involved, but likewise the philosophers and theologians.

The need for a meaning of death has been brought to the forefront within the medical profession with the discussions of abortions, euthanasia and transplantation of organs. Time or moment of death is a factor to be considered in all three.

Though death is a critical issue in numerous legal proceedings, the courts have seldom attempted to define the time at which death occurs. This has generally been a question of fact, left to be established by the Medical testimony of the time.

"Death" has been defined legally as the "cessation of life."[1] A California court,[2] in 1950, states death does not occur until "the heart stops beating and respiration ends." The court further noted death is an event that takes place at a precise time. A decree of the Arkansas Supreme Court interpreted death to mean "a total stoppage of the circulation of the blood, and a cessation of the animal and vital functions consequent thereon, such as respiration, pulsation, etc. ***"[3]

Another legal text[4] has defined death to mean the termination or cessation of life; the state or condition of being dead. Death is the antithesis of life, and it occurs precisely when life ceases.

The aforementioned legal definitions of death are subject to criticism, both legally and medically. The definitions are either too general in placing death in opposition to life, or they are subject to medical criticism by those medical authorities who contend the cardio-respiratory test often fixes the time of death too late. Many physicians now contend the cessation of brain activity should provide the criteria for fixing the time of death.

Modern life-supporting techniques have made it possible to sustain the cardio-respiratory functions after those proponents of a "brain death" theory would contend "death" occurred with an earlier cessation of the brain function. It has been reported that the determination of the final cessation of the brain function can be made with the same certainty as the determination of the last heart beat.[5]

The medical profession is presently attempting an analysis of the concept of death

(Continued on Page 613)

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IN-91-4C

(Continued from Page 610)

and the methods by which death can be determined to be a fact. This is as it should be.

In a presentation[6] to the First World Meeting on Medical Law, Gunnar Biorck[7] pointed out that physicians never deal with life and death in the abstract, but always with life and death of an individual. He too reduced death to the end of life and opined that this further required any concept of death to be based upon what we consider life to be. This would then require a consideration of the varying levels of life and a determination of where meaningful life exists, according to Dr. Biorck.

A need exists for a definite standard which comports with modern medical knowledge for fixing the time of death, be it either "heart death" or "brain death."

While common law courts have never convicted a medical practitioner either of shortening the life of a terminal patient or for refusing to render life sustaining aid,[8] a practical decision is needed as to when a physician can legally discontinue aid to a patient with an infinitesimal chance of recovery. In the era of the transplant, a physician needs to know when he can legally remove the transplant organ.

The pursuit of a legal definition of death has led to numerous proposals. One approach in determining a legal death, would require both the legal and medical professions to re-examine their attitude toward life and death. Included could be a reconsideration of the criteria of the law of homicide.[9] This suggestion was made with the apparent idea of establishing what a physician must do to avoid a charge of homicide. The proponent of this theory, after outlining the elements of common law murder, sought to classify the "flipping off" of a respirator switch in terminal cases as an act of omission, instead of an act of commission which would provide the first essential element of the crime. Such a change in our homicide criteria could require legislation; however, it has been argued that legislatures should refrain from attempting to define the time at which death occurs.[10]

It is interesting to note that while The Conference of Commissioners on Uniform State Laws has under study a Uniform Anatomical Gift Act, nowhere in this proposal is an attempt made to define the moment of death; and in fact, no preference for a criteria for this determination is expressed.[11] This act has been proposed as a result of the transplant advances. The Act seeks to eliminate the multitude of legal procedural problems involved in the transplant procedures; however, ethical and moral problems remain to be resolved.

Section 7 (a) of this proposed act places the responsibility for determining the time of death upon the donor's physician in attendance and this act would preclude such physician from being a member of the surgical team which transplants any organ from the donor to another person.

This proposal gives the attending physician the right to use his own method of determination—and yet proceed in the best interest of his patient rather than in the interest of successful transplantation.

Much has been written and much will be written on death as further advances are made, particularly in the fields of organ transplantation and life-support technology. While the need to define death remains, the legal profession of necessity must have a definition of death based upon the definition adhered to by the medical profession. If death is to be defined, however, physicians must first agree on applicable criteria. Perhaps the Declaration of Sydney is a step in this direction.

Declaration of Sydney

A STATEMENT ON DEATH

Adopted by the 22nd World Medical Assembly

August, 1968

The determination of the time of death is in most countries the legal responsibility of the physician and should remain so. Usually he will be able without special assistance to decide that a person is dead, employing the classical criteria known to all physicians.

Two modern practices in medicine, however, have made it necessary to study the question of the time of death further: (1) the ability to maintain by artificial means the circulation of oxygenated blood through tissues of the body which may have been irreversibly injured and (2) the use of cadaver organs such as heart or kidneys for transplantation.

A complication is that death is a gradual process at the cellular level with tissues varying in their ability to withstand deprivation of oxygen. But clinical interest lies not in the state of preservation of isolated cells but in the fate of a person. Here the point of death of *the different cells and organs* is not so important as the certainty that the process has become irreversible by whatever techniques of resuscitation that may be employed. This determination will be based on clinical judgement supplemented *if necessary* by a number of diagnostic aids of which the electroencephalograph is currently the most helpful. However, no single technological criterion is entirely satisfactory in the present state of medicine nor can any one technological procedure be substituted for the overall judgement of the physician. *If transplantation of an organ is involved, the decision that death exists should be made by two or more physicians and the physicians determining the moment of death should in no way be immediately concerned with the performance of the transplantation.*

Determination of the point of death of the person makes it ethically permissible to cease attempts at resuscitation and in countries where the law permits, to remove organs from the cadaver provided that prevailing legal requirements of consent have been fulfilled.

The World Medical Assembly adopted the above statement on death in August, 1968. This important statement was reached after several years of careful investigation. It can be noted that no attempt to define the time of death is made; however, it is stated that the responsibility should remain with the physician. The Council continues studies aimed at a workable definition of death. Few would disagree such is needed.

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Active Alabama Doctor Approaches His 100th Birthday

Next May 23rd, Alabama will be able to boast a centenarian still active in the medical profession. He is Dr. Joseph Davis Heacock, a general practitioner, member of the Jefferson County Medical Society.

The two accompanying pictures show him as he is today (a recent photograph by *The Birmingham News*) and as he was eight years ago, leading a Tuscaloosa parade in a vehicle that is almost obsolete as a method of travel.

Born in Alpine, Ala., May 23, 1869, Dr. Heacock attended Howard (now Samford) College, when it was located in Marion, and later Tulane. He also had special courses at Harvard, New York University, and other eastern universities.



He has three children—Mrs. James Alto Ward (the former Linda Belle Heacock), Mrs. E. H. Wrenn (the former Louise Heacock), and Dr. Joseph Davis Heacock, Jr., dean of the School of Religious Education, Southwestern Baptist Theological Seminary, Fort Worth; and 13 grandchildren.

An award made to laymen for outstanding work in the respiratory diseases, named for Dr. Heacock, has numbered among its recipients Gov. Albert Brewer, Senator Jim Allen, and Vincent Townsend, vice president of *The Birmingham News*.



Dr. Heacock

The 1969 American Industrial Health Conference will be held April 21-24 in Houston, Texas, with headquarters at the Shamrock Hilton. This medical-nursing conference is co-sponsored by the Industrial Medical Association and the American Association of Industrial Nurses.

* * *

The government is demanding miracles of the health professions, particularly in the slum areas, Dr. Gerald D. Dorman, president-elect of the American Medical Association, said in an interview. Such demands constitute "intellectual blindness" and are contributing to health problems that are beyond the control and responsibility of the doctors and allied arts," he said.

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Contraindication: Penicillin hypersensitivity.

Warnings: In rare instances, penicillin may cause acute anaphylaxis which may prove fatal unless promptly controlled. This type of reaction appears more frequently in patients with a history of sensitivity reactions to penicillin or with bronchial asthma or other allergies. Resuscitative drugs should be readily available. These include epinephrine and pressor drugs (as well as oxygen for inhalation) for immediate allergic manifestations and antihistamines and corticosteroids for delayed effects.

Precautions: Use cautiously, if at all, in a patient with a strongly positive history of allergy.

In prolonged therapy with penicillin, and particularly with high parenteral dosage schedules, frequent evaluation of the renal and hematopoietic systems is recommended.

In suspected staphylococcus infections, proper laboratory studies (including sensitivity tests) should be performed.

The use of penicillin may be associated with the overgrowth of penicillin-insensitive organisms. In such cases, discontinue administration and take appropriate measures.

Adverse Reactions: Although serious allergic reactions are much less common with oral penicillin than with intramuscular forms, manifestations of penicillin allergy may occur.

Penicillin is a substance of low toxicity, but it possesses a significant index of sensitization. The following hypersensitivity reactions have been reported: skin rashes ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; and reactions resembling serum sickness, including chills, fever, edema, arthralgia, and prostration. Severe and often fatal anaphylaxis has occurred (see Warnings). Hemolytic anemia, leukopenia, thrombocytopenia, and nephropathy are rarely observed side-effects and are usually associated with high parenteral dosage.

Administration and Dosage: Usual dosage range, 125 mg. (200,000 units) three times a day to 500 mg. (800,000 units) every four hours. For infants, 50 mg. per Kg. per day divided into three doses.

See package literature for detailed dosage instructions for prophylaxis of streptococcus infections, surgery, gonorrhea, and severe infections.

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V-Cillin K® (potassium phenoxymethyl penicillin, Lilly), Pediatric, for Oral Solution, 125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc. of solution (approximately one teaspoonful). [042567A]

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Report On Thyroidectomy Performed Under Hypnosis

Ira B. Patton, M. D.

Oneonta, Alabama

Many major surgical operations have been performed under hypnosis. Most of them under hypnosis combined with another anesthetic. However, after checking all available files, including the AMA reference library, the following is the first known report on a thyroidectomy performed in the United States under hypnosis as the only anesthetic.

The operation was performed October 21, 1954 in what was then known as Gordon-Patton Hospital of Oneonta, Blount County, Alabama. The name was later changed to Doctors' Hospital and ceased operation January 1968. The procedure was discussed with Dr. William S. Kroger, formerly of Chicago, Illinois, and presently practicing in Beverly Hills, California. Dr. Kroger is the author of several books and numerous articles on hypnosis and is recognized as one of the world's leading authorities on the practical application of hypnosis. Subsequent to this, Dr. Kroger performed a thyroidectomy under hypnosis. This was published in book form in a book entitled "Hypnosis in Medicine and Surgery" by Julian Press, New York City.

Our case was not published immediately because it was necessary for me to enter the army in January of 1955 after the operation was performed in October and I did not return from the army until 1957. By the time I was re-located and settled Dr. Kroger had performed his thyroidectomy under hypnosis. In the years since then time became less and less available for writing. However, when Doctors' Hospital closed this year we were reminded that some of the participants and witnesses of the operation may fall by the wayside in years to come. We felt that the case should be published while all the people who participated in the operation are living. The case and records are well documented and authentic witnesses are still available.

The patient was a 32-year old, white, married female who had previously had a delivery under hypnosis. She was suffering from a large, toxic goitre and was seen in consultation by Dr. William D. King, internist, of Birmingham, Alabama. Dr. King did not witness the operation. However, he evaluated the patient prior to surgery and recommended surgery.

The patient was given two teaspoons of Noctec at bedtime prior to surgery. The following morning at 6:30 she was given two additional teaspoons of Noctec and 1/200 grain of atropine sulphate.

The operation was begun at 8:00 A. M. The anesthetist present was Miss Alberta Boggin, at that time chief nurse anesthetist

at the University Hospital, Birmingham, Alabama. Miss Boggin, R. N. had been invited to observe the operation and administer additional anesthetic if required. No additional medication of any kind was administered. Miss Boggin is now anesthetist at Blount Memorial Hospital, Oneonta, Alabama. The surgery was performed by our surgical consultant, Dr. R. C. Green of Birmingham, Alabama. His first assistant was Dr. William Sutton of Blountsville, Alabama, his second assistant was Dr. Lewis Kirkland. Dr. Kirkland was associated with me in practice at that time but now is practicing in Montevallo, Alabama. The scrub nurse was Mrs. Frank Gillian, R. N. Her present address is 2538 Augustine Drive, Parma, Ohio. Our laboratory and X-ray technician, Mr. Ralph LeCroy, took color photographs of the operation. Mr. LeCroy is still in our employ. I was present in the operating room and occasionally talked to the patient, as did Dr. Green, and was available for reassurance if required. No reassurance of any kind was necessary for the patient. The patient was calm, relaxed and alert throughout the entire procedure.



It was necessary, however, for the patient and me to reassure the surgeons from time to time.

Due to the size and vascularity of the goitre, in spite of pre-operative treatment with propothyrouricil followed by lugols solution, some slight technical difficulty and slightly more than the usual degree of bleeding was encountered. However, it was comforting while working near the recurrent laryngeal nerves to have the patient able to speak to us clearly. The surgery was completed at 9:30 A. M. The patient returned to her room in a wheel chair and had a cup of coffee with her husband. After this she went to bed and we decided to remove her hypnotic anesthesia for her own protection. At 2:45 P. M. she was given 75 milligrams of Demerol for headache. On October 23, at 3:30 P. M., she was also given 75 milligrams of Demerol. These are the only narcotics or analgesics that she received during her post operative period. We did not feel that it was safe to completely remove the patient's perception of pain during the post operative period. Otherwise the post operative pain could also have been controlled by hypnotic technic.



The patient was discharged from the hospital recovered from her thyroidectomy on October 30, 1954.

ADDENDUM:

Two months later the same patient had a fibroadenoma removed from the breast with no premedication or anesthetic whatsoever. This procedure was witnessed by Dr. Ralph Hobbs, Birmingham, Alabama. Dr. Hobbs had performed orthopedic surgery at Blount Memorial Hospital and stopped by Gordon-Patton Hospital for the purpose of witnessing the surgery. Immediately after the operation was performed the patient put her clothes on and went home.

ROY CURTIS GREEN, M. D.
811 So. 20th St.
Birmingham, Alabama 35205

March 29, 1968

Ira B. Patton, M. D.
Oneonta, Alabama

Dear Doctor Patton:

I was called to see the patient in consultation, prior to the surgery. At this time, the patient requested to have surgery under hypnosis, by Doctor Patton. This patient had a bilaterally enlarged thyroid, a toxic goiter. She was thoroughly convinced that she could undergo surgery under hypnosis.

On the morning of surgery, she was called into Doctor Patton's office and sat down to discuss the operation. Then he told her to get up and go into the operating room and that we would be back later. She was told that she would have an anesthetist there in case an anesthetic was required. Miss Boggins was the anesthetist. The patient got up on the operating table and was prepped. Glucose was started, in case some anesthesia was required, other than the hypnosis, so that the anesthesia could be given immediately. The patient was draped in the usual manner and an incision was made (collar incision). The whole procedure was carried out under hypnosis without additional anesthesia. The patient talked during the operation. She would ask occasionally if she would be allowed to swallow, if the blood pressure cuff on her arm could be loosened and stated that her feet were cold. She showed no sign of having any pain pertaining to the surgery itself. She was told by Dr. Patton that she would tell me if she was having pain. Rather, periodically, she would speak up and say "Doctor Green, I am not having any pain." Other than that the patient seemed to be conscious of what was going on, but had complained none during the operation.

After the wound was closed and the patient was bandaged, she was sent back to the room



and she was given coffee by Doctor Patton. They sat and discussed the operation in her room, some few minutes after the surgery.

I received a letter a few days later from the patient, relating her description as to what happened and what she expected in the operating room. She stated that she always thought that in surgery, everything would be serious, quiet and very dignified. Then she stated that she had had a good bit of discussion of football and probably too, a couple of good jokes, during the time of the surgery. Otherwise, she had no feeling about the surgery at all. She came through the surgery without any particular anxiety or nervousness.

Roy Curtis Green, M. D.

RCG/sm

Calendar of Annual Meetings

Medical Association of the State of Alabama

1969, April 24-26, Carriage Inn, Huntsville

1970, April 30-May 2, Mobile

1971, April 22-24, Birmingham

1972, April 20-22, Montgomery

1973, April 18-21, Mobile

Clinical Evaluation Of Oral Contraceptives In Respect To Weight Change And Body Measurements

L. Clark Gravlee, M. D.

Birmingham, Alabama

Many physicians are now being faced with answering questions from a large segment of our population presently taking potent hormonal preparations for an objective other than the control of disease. Unfortunately, one of our greatest voids is in our knowledge of some of the more or less serious side effects encountered by healthy patients on a regimen of oral contraception. A more intelligent answer to the patient who presents the question of possible changes in her weight and figure has been for the most part a difficult one to achieve. Many patients seem to have a pre-conceived idea, usually from either the lay press or their contemporaries, that their figure will indeed change should they embark on a program of oral contraception. This fear of possible figure changes, with all of its ramifications such as new wardrobe, appearance, etc., could possibly be a severe deterrent to the patient from utilizing this most effective means of contraception. Oral contraception has been proved nearly 100 per cent effective and provides an acceptability of an order higher than that of any previous method of contraception.[1]

MATERIAL-METHOD:

The purpose of the study was to determine the effects, if any, of Norinyl 1 mg (norethindrone 1 mg, mestranol 0.05 mg) and Norinyl 2 mg (norethindrone 2 mg, mestranol 0.01 mg) on weight and/or figure changes. There were 64 patients initially placed in this evaluation. Thirteen of the patients took Norinyl 1 mg for a period of three months or longer. Thirty-seven of the patients took Norinyl 2 mg for a period of three months or longer. Fourteen patients who were included in this medication group dropped out of the program within the first two months. Table I outlines the reasons for the drop outs. Forty patients not using any systemic form of contraception were employed as a control. However, only 34 patients from the control group ultimately followed through the program.

TABLE I

DROP OUTS FROM STUDY

Patients did not return to office	12
Patient had emergency surgery (appendectomy)	1
Patient had excessive weight gain	1

All patients were nulliparous and postpartum with ages ranging from 18 to 35 years. Prior to admission into the study all patients were given an initial physical examination and Papanicolau Smear. No patient showing evidence of gynecological pathology was admitted into the study. Each patient was given a repeat physical examination and Papanicolau Smear at the end of six months.

Each patient received a dispensing package of 20 tablets of Norinyl 1 or 2. They were instructed to begin taking their first tablet on the fifth day of their menstrual flow and one tablet daily thereafter. At the initial examination, the patient's weight, measurement of the chest, waist, hips, and bra cup size were recorded, and again at the end of each month thereafter, when the patient returned for an additional month's supply of medication. During each visit, every patient was personally interviewed regard-

Norinyl 1 mg, Norinyl 2 mg graciously supplied by Mr. Jacque McQuaig, Clinical Research Associate, Syntex Laboratories, Palo Alto, California.

TABLE II

REPORTED COMPLAINTS

Nervousness	2 patients
Spotting during cycles	2 patients
Kidney trouble	1 patient
Breast tenderness	2 patients
Amenorrhea (1 month)	1 patient
Decreased libido	1 patient
Severe dysmenorrhea	1 patient
Dizziness	1 patient
Weight gain	2 patients
Acne developed	1 patient

ing her comments and/or complaints while on the medication. Table II records the complaints reported.

RESULTS:

The comparative results of this evaluation are outlined in Table III. The results were tabulated as per number of patients and the percentage within each group. The patients were very pleased with the results of taking Norinyl 1 and Norinyl 2, as can be seen from the tabulation of complaints reported in Table II. There were no cases reported as having developed thrombophlebitis, cancer, heart trouble or excessive water retention.

TABLE III

COMPARATIVE RESULTS

	Total Number	Gain	Loss	No Change
I. Weight Changes				
Norinyl 1 mg	13	8-61.5%	3-23%	2-15.5%
Norinyl 2 mg	37	22-59.5%	8-21.5%	7-19%
Control	34	16-47%	12-35%	6-18%
II. Chest Measurements				
Norinyl 1 mg	13	5-38.5%	3-23%	5-38.5%
Norinyl 2 mg	37	17-46%	8-22%	12-32%
Control	34	8-23.5%	6-17.5%	20-59%
III. Waist Measurements				
Norinyl 1 mg	13	4-31%	6-46%	3-23%
Norinyl 2 mg	37	13-35%	12-32.5%	12-32.5%
Control	34	12-35.0%	11-32.5%	11-32.5%
IV. Hip Measurements				
Norinyl 1 mg	13	4-30.5%	5-38.5%	4-30.5%
Norinyl 2 mg	37	18-49%	15-40.5%	4-10.8%
Control	34	11-32.5%	5-14.5%	19-56%

SUMMARY AND CONCLUSION:

Two groups of patients were evaluated in regard to figure changes while undertaking a course of oral contraception. They were simultaneously compared with a similar group of patients who used other than oral forms of contraception. The results tabulated in Table III were not subjected to any tests of significance, but it would appear that in all of the categories tabulated there were no appreciable differences between the control group and the two other groups taking medication. It was very interesting to note that patients not taking any medication gained in their waist measurement as much as the patients taking the maximum dosage of Norinyl.

The results thus far on this preliminary evaluation lead me to believe that differences in weight and figure changes could reasonably be attributed to transient weight changes not actually related to specific drug therapy.[2] These changes being due to many extraneous factors such as psychological stimuli influencing eating habits, bowel and urinary excretions, as well as degree of metabolic activity. It is hoped that a long term study encompassing many patients will average out many of these extraneous factors and lead to more meaningful conclusions. Nevertheless, based on the results of this preliminary evaluation, there is no appreciable change in the weight or figure of women taking Norinyl 1 mg or 2 mg.

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Learning And The Development Of Frustrations

Wallace Marshall, M. D.

Montgomery, Alabama

Learning with resultant frustrations plays an important role in generating adverse behavior such as hostility in animals and humans. Such human behavior has assumed a particularly significant role in producing public protestations, demonstrations and disobedience to lawful authority.

Purposes of this article are to demonstrate how various environmental stimuli can produce frustratory behavior. Few attempts have been made to classify such reactions. Our further consideration of learning and how frustrations can develop might assist physicians and other students of behavior to better comprehend how these reactions take place.

Ethics in our society are weakened or even replaced by aggressions of individuals over weaker members as the result of the constant competition over many physical and psychologic factors. Such might result in withdrawal of the oppressed individual from his environment, or it may produce marked depression. These are defense reactions. They resemble the solace a person obtains, when he becomes sensitized to ragweed, and takes an ocean voyage. It is also the basis for the Wier-Mitchell therapy for certain neuroses by taking the sensitized individual from his mentally irritating environment. This has been termed "the rest cure."

Obviously, constant competition continues throughout one's life span. Such occurs hourly in the business world. Resulting defeats can produce frustrations which can be expressed through one's hostility toward his tormentor, but can be observed also throughout the entire animal kingdom. Stronger puppies seize food from their weaker litter mates. The tough little boy grabs toys from his weaker playmate. The business tycoon forecloses on his competitor or undersells him driving him to possible bankruptcy or some other type of ruin. This behavior follows the Darwinian concept that only the strongest survive. Adherence to religious teachings has not appeared to control adequately many unethical human practices which are frequent in democratic, communist and monarchist societies. It can become especially rampant and virulent wherever anarchy exists.

Tinbergen[1] stressed that our understanding of behavior is affected adversely by our ignorance as to the causes and effects of our brains and their proper control. Such might well be the most urgent task of our society for its survival as well as for the survival of all life on earth.

Frustrations would not occur, nor could learning take place if all of the afferent neural tracts did not develop or if, for any reason, such became non-functional early in life. These perceptive avenues are composed of the visual, auditory, olfactory, taste and the tactile neural pathways which connect with their separate recipient areas within the cerebral cortex. Learning takes place whenever one or more of these normally operating afferent neural pathways become stimulated by one's environment. These tracts transmit neural impulses which produces probable neurochemical changes in these recipient cortical centers. DNA and RNA changes may be produced by such neural impulses from the afferent pathways, with possibly other

presently unknown neurochemical changes of electrochemical import. These resultant changes are stored in the recipient cortical cells. We call this memory. Thinking can be considered as the recall of stored information and may be connected with the use of the many association tracts which interconnect these recipient cortical centers which have stored energy from previous learning episodes.

One trial or multiple trial learning must be dependent upon several important additional factors. For example, it is important to ascertain the status of the afferent systems. In such studies, heredity surely must play an important part. Obviously, the current health status of the cortical recording centers should be obtained, where heredity, again, seems to play an important part. The size or caliber of the sensory stimuli must be considered. In other words, the dosage of the neural stimuli should be known, whether these are of minimal or maximal intensity. The length of time such stimuli operate must be known also. Of major importance is the consideration of the results from previous sensitizing experiences in the recipient cortical cells, since previous learning episodes with associated neural stimuli (psychoallergens) may exert sensitizing influences from previous learning experiences Here, then, we seem to be dealing with an allergic phenomenon, for previous sensitizations within these recipient cortical centers might produce hyperallergic responses when further associated sensory neural impulses meet with such sensitized states within these cortical cells.

Short and long term memory seems to be dependent directly upon the above points. Further learning attempts might produce allergic-like behavioral manifestations. Or excessive learning in the form of "brainwashing" can wreak havoc upon the storage of data from previous learning. Furthermore, these cortical centers, which store learning, can be affected by hypnotic trances, various pathologic lesions, such as brain tumors, cerebral infarcts and thrombi, fevers, and a host of other disease processes, including the introduction of foreign bodies (shrapnel, bullets), and other forms of trauma, such as the effects from surgery, etc.

It seems logical to assume that an individual must possess at least a modicum of intelligence to learn. My idea of intelligence is the ability to learn, or more specifically, for the cortical areas to absorb and to store the results of afferent neural sensitizing phenomena in these centers where certain neuroelectrochemical changes have resulted from the various afferent neural impulses. Not alone must these cortical centers store such learned data, but the individual must be able to perceive these changes. Furthermore, these sensitized cortical centers must be able to release this data to other cerebral and thalamic centers upon the will of the individual. This constitutes thinking.

Pathology may occur within any of these three categories of intelligence functioning. As an example, dyslexic patients are unable to use the stored data obtained from former cortical sensitizations. A great deal of public interest has been focused on this particular disorder lately.

The above psychoallergic theory[2] was first introduced by Marshall in 1936. To recapitulate, the main theme of this biologic approach to behavior stressed the importance of the neural impulses from the five avenues of perception (seeing, hearing, smelling, taste and touch). Neuroelectrochemical changes are thus produced and stored in the various recipient cortical areas of the brain. These neural sensitizations can produce learning through the allergic-like changes which take place within these cortical centers. The entire process exhibits the characteristics of other allergic phenomena. Among these are the refractory periods observed when an individual is bombarded by strong psychoallergens—as when a bird is overcome by the gaze from a serpent, or when two fighting cocks remain frozen (similar to catatonic

rigidity) as they face each other. Various hypersensitizing episodes, exemplified by overlearning, can produce manic behavior, examples of which we all have observed from time to time, as when a student throws a book in disgust following an extended studying episode, etc. Such is a frustratory reaction which results from excessive afferent stimuli affecting the recipient cortical cells because of hypersensitization in these areas.

As with the case of the physical allergies, it is not known whether or not antibodies are produced by these learning sensitizations. However, learning studies with Planaria offer indirect proof that antibodies might be produced from learning episodes. When Planaria are bisected and are allowed to regenerate their missing head or tail segments, they still retain their previous learning behavior.

Presently there is no explanation for this phenomenon other than previous learning sessions with Planaria had produced antibodies as the result of such learning episodes, and that their circulatory systems had carried these antibodies to their vital organs where they became lodged. Hence, further related learning (sensitizations) produced more antibodies which reacted with the previously formed antibodies. This may well be the basis for recognition psychologically. It may be related also to cognition and memory.

The psychoallergist may state that excessive learning can produce the further overabundance of associated antibodies from the sensory stimuli. Each learning process and its neurophysiochemical changes thus produced in the recipient areas of the brain, are specific for the particular learning process. When learning becomes excessive the antibody formation might be accelerated and, when conflicting behavior is introduced, as with opposite psycho-allergens, then the possibility occurs that frustration may result. Such might be explained through the incompatibility of the previously learned antigens with those of recent origin, particularly when conflicting antibodies meet as the result of these cortical sensitizations.

Frustration has been employed as a catch-all term. Silver[3] stressed the frustrations experienced when considering the reading problem such as dyslexia. He mentioned those frustrations to be overcome in dealing with complex reading problems. He mentioned the frustrations produced by the gap in knowledge, the frustrations of teachers and school administrators, those frustrations of the various researchers and practitioners and the frustrations of parents who wish to help their children with various reading disabilities.

It is interesting to recall that Freud did not use the mechanisms of frustration to explain psychic conflicts which evolved into neuroses and psychoses.

Frustration is defined as "a condition of increased emotional tension resulting from failure to achieve sought gratifications and satisfaction ordinarily as a result of forces outside of one's self."[4] Another definition for frustration is "the condition that results when an impulse to act or the completion of an act is blocked out or thwarted, preventing the satisfaction of attainment."[5]

Deese and Hulse[6] stressed that organisms can be frustrated experimentally in various ways. Wolman[7] observed that, in some humans, frustration is accepted with little change, while in others even a mild frustration produces unbearable consequences. Hofling[8] writes that frustration can lead to hostility which he thinks is both inevitable and automatic in infants.

The term frustration is employed psychologically and psychiatrically in one huge, neat and undifferentiated package. It is my wish to dissect and examine it further under magnification.

Some energy or force is employed to produce frustration. Such a force which inter-

feres with or prevents volition is the *frustrator*. The organism or any part of it becoming inhibited or inactivated by a frustrator is the frustrant. Frustration only occurs in a viable organism or animal, invertebrate or vertebrate. The noxious effects from frustration can be either temporary or permanent, partial or complete by its interference with one or more physiologic and/or psychologic functions in the viable frustrant who also must be cognitive of such happenings.

Frustration can affect the individual through his own actions, as exemplified by trichotillomania, dermatothasia, bromidrosiphobia, the production of neurotic skin excoriations, or even by suicide (auto-frustration). Or frustration can be produced by other individuals or forces from without (heterofrustration) as exemplified by murder or by acts of God, as by the production of injuries or even death from lightning, tornadoes, etc. The culminating frustrant produces death itself, either from an autofrustrator or a heterofrustrator.

Hebb[9] mentions that problem-solving involves certain elements of frustration which can contribute to sources of pleasure as with the playing of chess or bridge. In such situations the frustration is usually of minor import and can be temporary in nature. But with the primary dyslexic person[10] the frustrant is probably congenital in type and permanent because of the inability of Brodman's areas 18 and 19 to assimilate and interpret properly the neurochemical cortical changes which are produced during the learning processes.

Sites of action, whereby frustrators can act upon frustrants, should be offered. Such may assist in the further comprehension of resultant inhibiting reactions.

Frustrators can involve any portion of the sensory nervous system; these are afferent in type and are exemplified by the application of an eye patch over the frustrant's eye. This blocks vision in that eye. Any sensory receptor and its nerve tract to the brain can be involved by a frustrator. Impacted cerumen affects audition in such an involved ear. Certain tumors or disease processes are able to disrupt such perceptual avenues of sensoria; and also other frustrants can produce disabilities within the various afferent systems. To repeat, such disruptions are peripheral in type.

When frustrators involve the cerebrum and cerebellum and their various interconnecting pathways, *central* or *cortical* types of frustration take place. Examples are the effects from anaesthetics, tumors and other disease processes, traumas to these areas, hypnotic trances, and related frustratory situations.

The motor pathways leaving the brain can be frustrated by similar pathologic events which are *efferent* in type. Examples are the frustrations produced by body, arm or leg casts, the use of handcuffs and related frustrators which interfere with muscular activities.

Similarly, the autonomic motor systems can be affected by various frustrators as by sympathectomies, neoplasms, etc. which interfere with autonomic functions such as flushing, sweating and similar autonomic physiology, with the possible genesis of various psychosomatic disorders.

Colleagues have asked how psychologic inhibitions should be classified. These have to do with certain drives and desires which become thwarted because of possible fear reactions as their consequences, if these are allowed to operate uninhibited. Perhaps these might be grouped in the central or cerebrocerebellar type. These are also of the autofrustratory types which were produced by previous learning experiences as has been mentioned.

The above attempts to classify the various types of frustrations and where they act might help to accelerate and to further our knowledge of these highly important behavioral reactions.

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Warnings—Watch for the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism, retinal thrombosis); if present or suspected discontinue the drug immediately.

British studies reported in April 1968[1,2] estimate there is a seven- to tenfold increase in mortality and morbidity due to thromboembolic diseases in women taking oral contraceptives. In these controlled retrospective studies, involving 36 reported deaths and 58 hospitalizations due to "idiopathic" thromboembolism, statistical evaluation indicated that the differences observed between users and non-users were highly significant. The conclusions reached in the studies are summarized in the table below:

Comparison of Mortality and Hospitalization Rates Due to Thromboembolic Disease in Users and Non-Users of Oral Contraceptives in Britain.

Category	Mortality Rates		Hospitalization Rates (Morbidity)
	Age 20-34	Age 35-44	Age 20-44
Users of Oral Contraceptives	1.5/100,000	3.9/100,000	47/100,000
Non-Users	0.2/100,000	0.5/100,000	5/100,000

No comparable studies are yet available in the United States. The British data, especially as they indicate the magnitude of the increased risk to the individual patient, cannot be applied directly to women in other countries in which the incidences of spontaneously occurring thromboembolic disease may differ.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or sudden onset of proptosis, diplopia or migraine. Withdraw medication if papilledema or retinal vascular lesions are found.

Since the safety of Ovulen in pregnancy has not been demonstrated, it is recommended that pregnancy be ruled out for any patient who has missed two consecutive periods before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the first missed period.

A small fraction of the hormone agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions—Pretreatment physical examination should include special reference to the breasts and pelvic organs, and a Papanicolaou smear.

Endocrine and possibly liver function tests may be affected by Ovulen. Therefore, it is recommended that such tests if abnormal be repeated after the drug has been withdrawn for two months.

Pre-existing uterine fibromyomas may increase in size under the influence of progestogen-estrogen preparations.

Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation.

In breakthrough bleeding, and all irregular vaginal bleeding, consider nonfunctional causes. Adequate diagnostic measures are indicated in undiagnosed vaginal bleeding.

Carefully observe patients with a history of psychic depression and discontinue the drug if severe depression recurs.

Any possible influence of prolonged Ovulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study.

A decrease in glucose tolerance has occurred in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be observed carefully while receiving Ovulen.

Because of the effects of estrogens on epiphyseal closure Ovulen should be used judiciously in young patients in whom bone growth is not complete.

The age of the patient constitutes no absolute limiting factor, although Ovulen therapy may mask the onset of the climacteric.

The pathologist should be informed of Ovulen therapy when relevant specimens are submitted.

Adverse Reactions—A statistically significant association has been shown between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: cerebrovascular accidents, neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement, secretion), change in weight, changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, allergic rash, rise in blood pressure in susceptible individuals, mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme and nodosum, hemorrhagic eruption, itching.

The following laboratory results may be altered by oral contraceptives: hepatic function: increased sulfobromophthalein and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T^3 uptake values; metyrapone test; pregnanediol determination.

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Before prescribing see Detailed Product Information.

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Alabama Department of Public Health

State Activates Gonorrhea Control Project

By

Catherine G. Lamar

For years, major emphasis in the area of venereal disease control has been placed on detection, control, and eventual eradication of syphilis. During 1967, however, this state passed a peak of syphilis morbidity and completed the second year of a downward trend.

In evaluating the venereal disease program for the Alabama Department of Public Health's 1966 activities report, W. H. Y. Smith, M. D., director, Bureau of Preventable Diseases made a prophetic observation: "The cases of gonorrhea continue to increase each year. No money has been appropriated for gonorrhea epidemiology and control; therefore, it is felt that many cases are not reported. Until syphilis is under definite control or more money is appropriated, little can be done to prevent a gonorrhea avalanche."

Following in the wake of decreased cases of syphilis and increased gonorrhea, the department conceived a Gonorrhea Control Program early in 1968. State funds amounting to $75,000 were allocated for the pilot project expected to span an 18 month period.

Several months later the National Communicable Disease Center requested permission to co-sponsor the project and authorized funding in the amount of $42,834. A contract agreement was signed between the two agencies in May.

The study actually involves three pilot projects in separate metropolitan areas of the state: Montgomery, Birmingham, and Mobile. In each area, a different method or a combination of several methods will be utilized.

In Birmingham cultures of cervices of approximately 30,000 females will be obtained from the following patient groups: admissions to Norwood Hospital; admissions to Jefferson County Health Department family planning and venereal disease clinics; and admissions to other health service organizations mutually agreeable to the contractor and the project officer. This is expected to yield a statistical study of the suspected number of carriers and provide an accurate sampling of the disease in this female population.

An important aspect of this project will include a 10-day period of prophylactic treatment for patients yielding positive cultures. A second culture will be made on these patients to check treatment and "cure" effectiveness.

Male and female patients with gonorrhea, as well as contacts and suspects of these patients, will constitute the target group for the Mobile area project. Epidemiology will be

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performed on all male and female patients receiving treatment at the Mobile County Health Department's venereal disease clinics. Infected male patients will be interviewed for contacts for a period of one month plus the duration of symptoms; infected females will be interviewed for a six week period. Intensive follow-up campaigns will be waged to insure examination, diagnosis, and treatment, as indicated, of all sex contacts.

The screening process will be combined with the epidemiological approach in the Montgomery area project.

Screening will be performed on admissions to venereal disease and planned parenthood clinics, admissions to the Montgomery County Joint Public Charity Clinic, and admissions to other health service organizations mutually agreeable to the contractor and the project officer.

All male and female gonorrhea patients being treated at the Montgomery County Health Department's venereal disease clinics will be interviewed for their contacts with the same epidemiological approach being employed as in the Mobile study.

Laboratory services constitute essential support for this program. During the 18 month duration of the project, approximately 45,000 cultures will be taken and processed using a new media which promises to be far superior to prior methods. The central laboratory in Montgomery will completely process all cultures taken in the Montgomery project as will the Birmingham Branch Laboratory for those taken in the Jefferson County area. The Mobile Branch Laboratory will culture only, with confirmation through fluorescent antibody examination being done by the central laboratory.

One of the major results of this program could be the development of a satisfactory carrying medium. This project offers an excellent opportunity to evaluate currently available media.

Presently, a full scale testing program for gonorrhea is not feasible except in areas having laboratory facilities. The organism *Neisseria gonorrhea* is a fastidious one which does not adapt easily to environmental changes. To obtain accurate results from tests, an organism must remain viable, neither multiplying nor dying but remaining as near to its natural state as possible. Experimentation has shown that no such media is available. Development of an effective carrying medium would facilitate testing by enabling screening on a state-wide basis with all cultures being processed by the central laboratory.

States throughout the country have reported increased incidence of this disease. Alabama, however, stands alone in its battle against gonorrhea. With launching of this pilot study she became the first state in the nation to activate a state-wide control attempt.

BUREAU OF PREVENTABLE DISEASES

W. H. Y. Smith, M. D., Director

Current Morbidity Statistics

1968

	Oct.	Nov.	*E. E. Nov.
Tuberculosis	110	109	98
Syphilis	61	48	117
Gonorrhea	476	420	275
Chancroid	5	2	2
Typhoid fever	0	0	1
Undulant fever	0	0	0
Amebic dysentery	0	0	3
Scarlet fever & strep. throat	378	585	122
Diphtheria	3	2	4
Whooping cough	8	4	10
Meningitis	3	3	6
Tularemia	0	0	0
Tetanus	0	1	1
Poliomyelitis	0	0	0
Encephalitis	0	0	0
Smallpox	0	0	0
Measles	1	0	22
Chickenpox	3	10	15
Mumps	7	0	32
Infectious hepatitis	39	34	36
Typhus fever	0	0	0
Malaria	0	1	0
Cancer	372	754	523
Pellagra	0	0	0
Rheumatic fever	9	13	14
Rheumatic heart	10	18	24
Influenza	37	86	83
Pneumonia	205	300	198
Rabies—Human cases	0	0	0
Pos. animal heads	3	1	0

As reported by physicians and including deaths not reported as cases.

*E. E.—The estimated expectancy represents the median incidence of the past nine years.

BUREAU OF VITAL STATISTICS
PROVISIONAL BIRTH AND DEATH STATISTICS AND COMPARATIVE DATA

Ralph W. Roberts, M. S., Director

SEPTEMBER 1968

Live Births / Deaths / Causes of Death	Number Registered During September, 1968			Rates* (Annual Basis)		
	Total	White	Non-White	1968	1967	1966
Live Births	5,588	3,710	1,878	18.9	20.5	20.7
Deaths	2,582	1,758	824	8.7	8.2	8.4
Fetal Deaths	114	48	66	20.0	19.8	21.9
Infant Deaths under one month	106	58	48	19.0	13.3	17.2
under one year	128	71	57	22.9	20.7	23.4
Maternal Deaths	4	1	3	7.0	6.5	4.9
Causes of Death						
Tuberculosis, 001-019	9	2	7	3.0	6.1	5.5
Syphilis, 020-029	4	3	1	1.4	1.7	2.1
Dysentery, 045-048	1		1	0.3	0.3	
Diphtheria, 055						
Whooping cough, 056						
Meningococcal infections, 057						0.3
Poliomyelitis, 080, 081						
Measles, 085						
Malignant neoplasms, 140-205	405	292	113	137.1	122.6	120.2
Diabetes mellitus, 260	45	31	14	15.2	13.0	17.6
Pellagra, 281						
Vascular lesions of central nervous system, 330-334	345	223	122	116.8	116.8	117.5
Rheumatic fever, 400-402	2	2		0.7		0.3
Diseases of the heart, 410-443	845	609	236	286.0	269.8	294.4
Hypertension with heart disease, 440-443	88	34	54	29.8	30.7	41.8
Diseases of the arteries, 450-456	82	55	27	27.8	21.5	14.9
Influenza, 480-483					0.3	0.3
Pneumonia, all forms, 490-493	48	28	20	16.2	14.0	19.7
Bronchitis, 500-502	6	5	1	2.0	2.4	1.4
Appendicitis, 550-553					0.7	2.4
Intestinal obstruction and hernia, 560, 561, 570	12	8	4	4.1	3.8	4.1
Gastro-enteritis & colitis, under 2, 571.0, 764	7	1	6	2.4	1.4	2.4
Cirrhosis of liver, 581	20	16	4	6.8	7.2	4.5
Diseases of pregnancy and childbirth, 640-689	4	1	3	7.0	6.5	4.9
Congenital malformations, 750-759	27	19	8	4.8	5.2	3.0
Immaturity at birth, 774-776	20	12	8	3.6	3.7	5.5
Accidents, total, 800-962	201	152	49	68.0	63.5	60.8
Motor vehicle accidents, 810-835, 960	110	88	22	37.2	32.8	34.9
All other defined causes	366	229	137	123.9	110.3	117.1
Ill-defined and unknown causes, 780-793, 795	133	70	63	45.0	41.3	32.8

*Rates: Birth and death—per 1,000 population
Infant deaths—per 1,000 live births
Fetal deaths—per 1,000 deliveries
Maternal deaths—per 10,000 deliveries
Deaths from specified causes—per 100,000 population

BUREAU OF LABORATORIES

Thomas S. Hosty, Ph.D., Director

NOVEMBER 1968

Examination of Intestinal Parasites	1,584
Examination of Malaria	2
Examination of Salmonella & Shigella (blood-feces-urine-food)	303
Examination of tubercle bacilli	3,902
Examination of gonococci	1,653
Serological tests for syphilis	28,174
FTA	95
Darkfield	4
Brucella	0
General Bacteriology (cultures for isolation and confirmation)	27
Staphylococcus (cultures for isolation and confirmation)	12
Examinations for diphtheria (cultures for isolation and confirmation)	17
Streptococci examinations	3,063
Mycology	46
Agglutinations	8
Vincent's Infection	5
Complement fixation tests	157
Tests for Phenylketonuria (PKU)	6,133
Cytology	2,012
Water Examinations	3,059
Milk and Dairy Products examinations	5,103
Sea Food Examinations	158
Examinations for Negri bodies (smears & animal inoculations)	350
Virology	16
Rh Factor Bloods	647
Miscellaneous	3,005
TOTAL	59,535

With a little help on the side, a body's own chemical compounds will conquer virus diseases, *Science*, the weekly journal of the American Association for the Advancement of Science, reports. Two doctors found a way to get the body to produce more of its own virus-fighting chemical, a compound called Interferon, and it was tried successfully on rabbits.

* * *

Emphysema and other respiratory diseases are stifling increasing numbers of Americans, and compounding the overall problem is the shortage of inhalation therapists and other professionals in the field of respiratory ailments. The facts were weighed at the convention of the National Easter Seal Society for Crippled Children and Adults.

PHYSICIAN PLACEMENT SERVICE IN ALABAMA

The Physician Placement Service of the Medical Association of the State of Alabama is designed to assist both physicians and communities. MASA members having knowledge of practice opportunities or wishing to relocate their own practices are urged to communicate with the Placement Service. For further information: write Mr. Emmett Wyatt, Executive Assistant, Medical Association of the State of Alabama, 19 South Jackson Street, Montgomery, Alabama 36104, or Telephone 263-6441.

Locations Wanted

General Practice—

Age 44, Medical College of Alabama, 1967, seeking associate practice in town of 12,000 plus population in central or south Alabama. LW-1

Age 56, Georgetown University 1938; seeking solo, group or associate practice, with general surgery. LW-2

Age 52; University of Chicago 1950; seeking group, industrial, institutional or student health position. LW-3

Age 31, Western Reserve, 1964; seeking group, associate or institutional practice. LW-4

Age 38; University of Oklahoma, 1955; seeking associate, institutional or industrial practice; in town of 10,000 plus population; interest in surgery. LW-5

Age 28; Medical College of Alabama 1966; seeking practice in town of less than 14,000 population to fulfill scholarship requirements. Available 1968. LW-6

Age 28; University of Tennessee, 1965; available November 1968. LW-7

Age 27, Medical College of South Carolina, 1966; seeking location in Gadsden area or in southern part of state in town of 5-7,000 population; available July 1, 1971. LW-7/1

Age 38; Medical College of Alabama, 1957; seeking location in south Alabama. LW-7/2

Internal Medicine—

Age 36, Medical College of Alabama, 1963; seeking solo, group, or associate practice. LW-8

Age 34; University of Mississippi 1960; Board eligible; seeking location in southern section of Alabama in city of 15,000 plus population. LW-9

University of Mississippi 1963; seeking group practice in city of 20,000-40,000 population. LW-10

Age 34; Hahnemann Medical College 1959; Board eligible, National Board; seeking solo, group, or associate practice. Available immediately. LW-11

Age 35; University of Tennessee 1958; Board certified; seeking group, industrial or institutional practice. LW-12

Age 37, Duke University, 1956; Board certified, seeking group, associate, or institutional practice. LW-13

Neurology—

Age 32, Medical College of Georgia, 1964, seeking assistant or associate, or institutional practice. LW-14

Age 31; Harvard 1962; Board eligible; National Board; seeking solo, group or associate practice. Available July 1969. LW-15

Age 30; Medical College of Alabama 1962; Board eligible; National Board; seeking solo, group, associate or institutional practice. Available January 1969. LW-16

Age 31; University of Virginia 1962; Board eligible; seeking associate or group practice. Available August 1969. LW-17

Age 29, Indiana Univ., 1964; Board eligible; seeking assistant or associate practice in city of over 100,000 population; available July 1, 1969. LW-17/1

Obstetrics-Gynecology—

Age 35, Vanderbilt University, 1950. Board eligible. LW-18

Age 49, University of Nebraska, 1943; Board certified, seeking group or institutional practice. LW-19

Age 34, Medical College of Virginia, 1961, Board eligible, seeking group or associate practice. LW-20

Age 33; University of Illinois, 1964; seeking associate practice. LW-21

Ophthalmology—

Age 33; St. Louis University, 1962; seeking solo, or associate practice; available July 1, 1969. LW-21/1

Radiology—

Age 39; Louisiana State University 1954; seeking solo or associate practice. Available July 1969. LW-22

Age 31; S. U. N. Y. College of Medicine, 1961; Board eligible; seeking solo, group, or associate practice. LW-23

Age 41; Cornell Univ. Medical School, 1953; Board certified; seeking group, or associate practice. Available immediately. LW-24

Age 51; Univ. of Texas Med. Branch, 1942; Board certified; seeking solo, group, or associate practice. LW-25

Surgery—

Age 30; Duke University School of Medicine, 1964; seeking location in larger cities. LW-26

Age 33; University of Missouri, 1961; seeking group or associate practice. Available January 1969. LW-27

Age 38; Emory University, 1956; Board eligible, seeking group, associate, or institutional practice. LW-28

Locations Wanted

(Continued)

Age 37; Faculty of Medicine, Manitoba, 1957; Board certified; seeking associate or institutional practice. LW-29

Age 34; University of Santo Tomas, 1961; Board eligible, seeking group or associate practice. LW-30

Age 35; University of Santo Tomas, 1956; Board eligible, seeking solo, group or industrial or associate or institutional practice. LW-31

Age 31; Medical College of Alabama, 1962; Board eligible; passed National Board; seeking assistant, associate, institutional or group practice in city of over 50,000. Available July 1969. LW-31/1

Urology—

Age 30; Louisiana State University, 1963; Board eligible, seeking associate, or group practice. LW-32

Physicians Wanted

General Practitioners—

Opportunity in town of 4,000 population in trade area of 50,000 population, located within 100 miles of two metropolitan areas in south Alabama. Industrial and farming area. 44-bed hospital. Office space and equipment available in new building with another physician. Several churches, schools, and service clubs. PW-1

Opportunity for group practice in town of 10,000 population in north Alabama. PW-2

Physician wanted to join 39 year old Medical College of Alabama graduate in a well established general practice in West Central Alabama town. Salary initially followed soon by full partnership. PW-3

Opportunity in community of 5,000 population in trade area of 30,000 population located in northeast Alabama where at present time there are only two active full time general practitioners. Modern offices or clinic facilities available. 48-bed accredited hospital and 52-bed skilled nursing home adjoining the hospital. Cities of approximately 75,000 population located within 25 miles distance. Agricultural and expanding industrial area. Numerous churches and schools. Country club and golf course being developed and water sports and outdoor activities offer recreational advantages. PW-4

For town of 2,000 population in trade area of 5,000 located in South Alabama, within 24 miles of large city of 37,000 population. Nearest hospital (50 beds) is 12 miles away. One physician presently in practice in town. Office space available. Military base, farming, and small industries afford resources. Numerous civic clubs, two schools, and five churches. PW-5

For town of 4,500 population in trade area of 10,000 to 15,000 with annual payroll of 4½ million dollars, located in north central Alabama. Within 75 and 85 miles respectively of two metropolitan areas with combined population of 2 million. Hospital privileges available in modern 30-bed hospital. A modern 40-bed extended care facility adjoins hospital. Excellent churches, schools and shopping areas. In the center of the best hunting, fishing and recreational area in the state. PW-6

Physician wanted to join well established partnership in Northwest Alabama city of 15,000 population. Two accredited hospitals, junior college, schools, churches, recreational activities. No obstetrics or surgery. New office building. PW-7

For city of approximately 15,000 population in north Alabama, with trade area of approximately 45,000 population. Hospital with over 100 beds, and expansion planned for next year. Nursing homes in the area. Industrial growth and agricultural region. Several churches and schools. Golf course, civic and fraternal organizations. PW-8

For partnership practice in clinic in town of 2,000 population in area of 10,000 population located in north-central Alabama. 40-bed hospital. PW-9

For assistant or associate in clinic located in town of 10,000 population located in northeast Alabama. 65-bed Hill-Burton hospital. PW-10

For associate practice in city of 6,000 population in area of over 10,000 population located in East-central Alabama. PW-11

For solo practice in county clinic located in East-central Alabama. Office, equipment and housing available. 70-bed Hill-Burton Hospital and 22-bed nursing home. PW-12

For town in southwest Alabama, approximately 1,000 population in trade area of approximately 5,000 population, within 60 miles of large city of 35,000. Nearest hospital is located 18 miles away. Arrangements available for office space. Small industries and agriculture. Civic clubs and golf course nearby. Churches and school. PW-13

For town of approximately 1,000 population in population center of 10,000 located in Southwest Alabama within 90 miles of the Gulf coast. City owned clinic is offered rent free and fully equipped. Hospitals are located in two nearby towns within 25 miles. This is principally an agricultural region, but there are military installations nearby. Numerous civic clubs, community concert series, and a country club offer recreational activities. PW-14

For town of 1,000 plus population in west-central Alabama in trade area of 20,000. Clinic available. Nearest city of approximately 70,000 population is located a distance of 17 miles. Farming, cattle, timber, and manufacturing plants are principal resources of the area. Churches, schools, and recreational advantages. PW-15

Opportunity for general practitioner to join a five-man group, practicing as a partnership. Each man in the group is either specialized or semi-specialized. The practice is physically located within a 70-bed hospital. Willing to pay qualified person $36,000 for the first year, with possible

(Continued on Page 636)

Physicians Wanted

(Continued)

partnership status in one year. Would consider a physician for locum tenens for three to six months at $2,000 per month. PW-16

For town of 3,600 population in trade area of 5,000-7,000 within 100 miles of two large cities and the Gulf Coast. 50-bed hospital located in the town. Office space available. Agricultural and expanding industrial area. Several churches and two schools. Recreational activities in the town as well as nearby—golf course, hunting and fishing. PW-17

Unusual opportunity for two general practitioners with military obligations satisfied at a modern fifty bed facility located 15 minutes drive from largest metropolitan center in north-central Alabama. Construction of a new two-story office building is scheduled to begin soon. PW-18

Opportunity in city of 5,000 population located in Northeast Alabama in trade area of approximately 10,000 population. Office space available. One physician died recently. Hospital and nursing home in the city. PW-19

Special Openings—

Specialist in the following fields: Internal Medicine, Pediatrics, Obstetrics-Gynecology and General Practitioners. 58-bed fully accredited general hospital with 91-bed addition recently completed. Modern new office space available. PW-20

Opportunity for general practitioners or internists for institutional practice at TB Sanatorium in North Alabama. PW-21

Opportunity for physician interested in joining a progressive public health tuberculosis control program working in Birmingham, Jefferson County. Provide outpatient medical services and some administrative duties. Fringe benefits and salary open. PW-22

Student Health—

New 75-bed facility to be occupied in late 1968. Present staff of seven full-time physicians. Salary negotiable. Appointments are full time with regular University benefits. PW-23

Full time salaried position of assistant director on staff of four 65-bed well equipped infirmary with adequate office space. Excellent laboratory and X-ray facilities. Liberal fringe benefits. PW-24

Obstetrician-Gynecologist—

Excellent opportunity for a trained Ob-Gyn man who would join a three-man partnership practice in city of 30,000 population located in southwest Alabama. Salary is proposed for the first 12 months, a limited partnership to begin at the end of twelve months, and full partnership to begin at the end of 24 months. PW-25

Dr. Pickering Heads Montgomery Society: Promotions Announced By Health Department





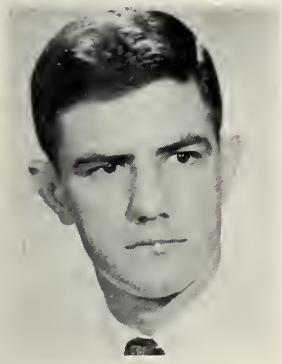
Dr. John Milton Pickering, whose M. D. degree is from the University of Alabama, is 1969 president of the Montgomery County Medical Society. Serving with him will be Dr. William B. Crum, vice president; Dr. William L. Smith, secretary-treasurer; and Dr. Paul D. Everest moves up to chairman of the Board of Censors.



Forest E. Ludden, director of the Bureau of Primary Prevention, Alabama Department of Public Health, has been appointed assistant to the state health officer. Billy Dabbs has been named acting bureau director, to replace him.



New Physicians Licensed to Practice in Alabama

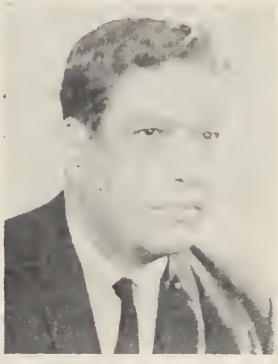


James Wayne Battle, Jr., M. D., University of North Carolina School of Medicine, 1965, Reciprocity with North Carolina—Intends to locate in Birmingham.

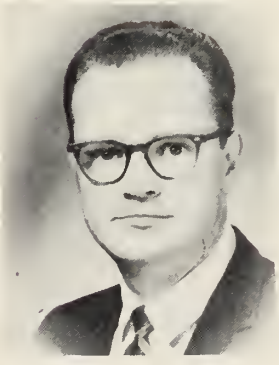


Frank Owen Evans, Jr., M. D., Cornell University Medical College, 1967, Reciprocity with National Board of Medical Examiners—Intends to locate in Birmingham.

James Bruce Beatty, M. D., University of Tennessee College of Medicine, 1956, Reciprocity with Tennessee—Intends to locate in Russellville.



Charles Henry Giles, M. D., Loma Linda University, 1965, Reciprocity with National Board of Medical Examiners—Intends to locate in Birmingham.





Ronald Robert DiNella, M. D., Vanderbilt University School of Medicine, 1960, Reciprocity with Tennessee—Intends to locate in Lester.



Michael Erin Harkey, M. D., Yale University School of Medicine, 1964, Reciprocity with National Board of Medical Examiners—Intends to locate in Mobile.



Joseph Hugh Keffer, M. D., Georgetown University School of Medicine, 1961, Reciprocity with National Board of Medical Examiners—Intends to locate in Montgomery (Maxwell AFB).





Avrom Carl Segal, M. D., Jefferson Medical College, 1962, Reciprocity with National Board of Medical Examiners—Intends to locate in Opelika.



James Albert Weiss, M. D., UCLA School of Medicine, 1965, Reciprocity with California—Intends to locate in Montgomery (Maxwell AFB).



Houston's "Big Meeting" drew doctors from Georgia and Florida as well as Alabama. In one of the accompanying pictures are (in that order): Dr. Forrest Bird, Dr. Clyde Smith, president of the Houston County Medical Society, and Dr. Michael DeBakey. . . . In the other, from left: Mrs. Rube Hundley, Mrs. Mary Wini Saxson, Mrs. Davis Haughton.



Dr. Ira L. Myers, state health officer, receiving the D. G. Gill Award plaque from the hands of Arthur N. Beck, director, Bureau of Environmental Health. The award honoring the late Dr. Gill, who served for 16 years as state health officer until his death in 1962, is in recognition of outstanding contributions in the field of public health. Dr. Myers is the first recipient.

Once-popular treatment for back pains was to have the seventh son of a seventh son stand or walk on the patient's back.



The pain of earache was allegedly relieved by holding a hot roasted onion to the ear.



For headache, a sovereign remedy was to wear a snakeskin round one's head.



A realistic approach to pain relief



'Empirin'®

Compound with Codeine Phosphate gr. 1/2 No. 3

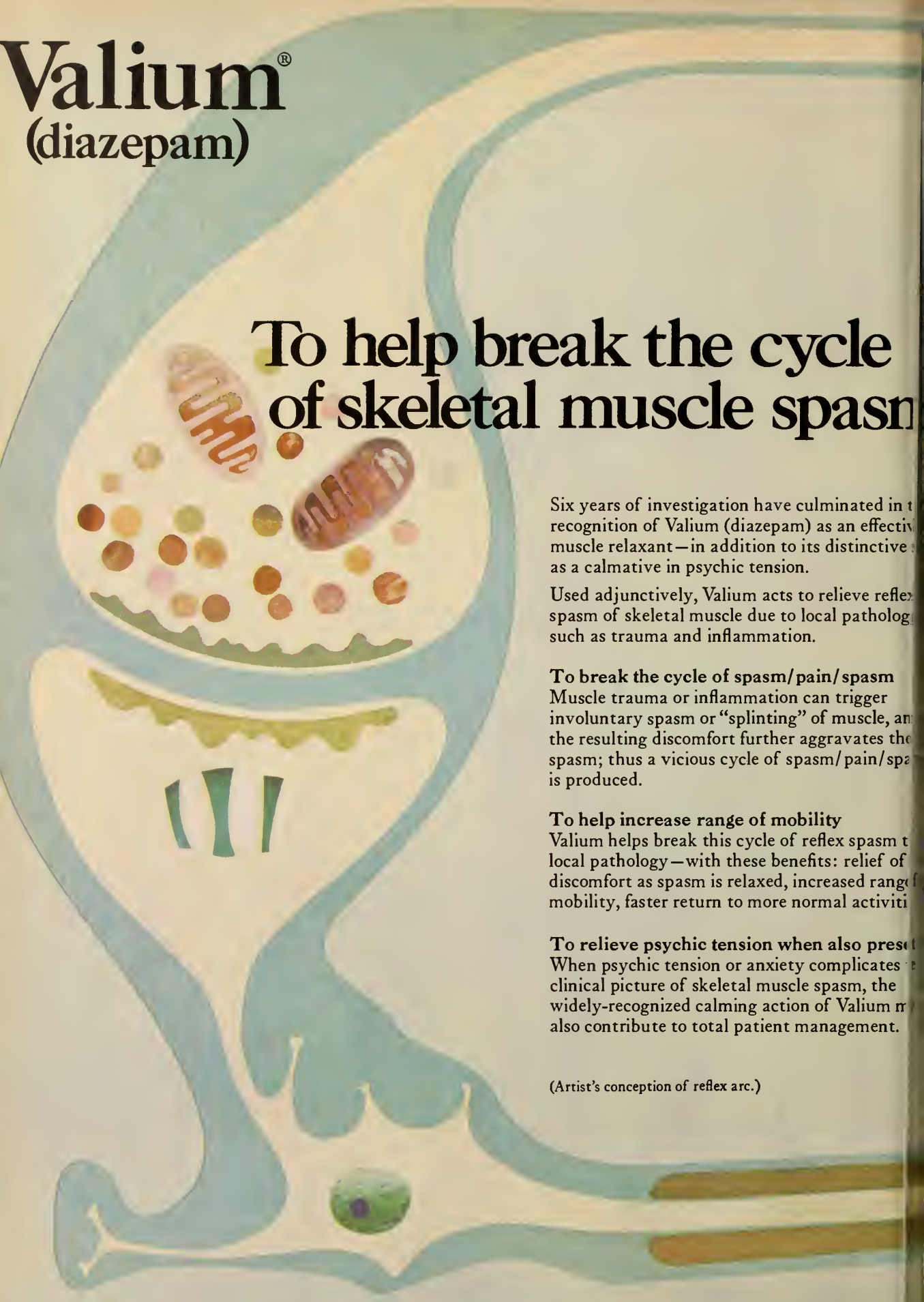
Each tablet contains:
Codeine Phosphate gr. 1/2 (Warning—may be habit forming), Phenacetin gr. 2 1/2, Aspirin gr. 3 1/2, Caffeine gr. 1/2.

Keeps the promise of pain relief

'W. & Co.' narcotic products are Class "B", and as such are available on oral prescription, where State law permits.

BURROUGHS WELLCOME & CO. (U.S.A.) INC.
Tuckahoe, N.Y.

Valium®
(diazepam)



To help break the cycle of skeletal muscle spasm

Six years of investigation have culminated in t recognition of Valium (diazepam) as an effectiv muscle relaxant—in addition to its distinctive as a calmative in psychic tension.

Used adjunctively, Valium acts to relieve reflex spasm of skeletal muscle due to local patholog such as trauma and inflammation.

To break the cycle of spasm/pain/spasm
Muscle trauma or inflammation can trigger involuntary spasm or "splinting" of muscle, an the resulting discomfort further aggravates the spasm; thus a vicious cycle of spasm/pain/spa is produced.

To help increase range of mobility
Valium helps break this cycle of reflex spasm t local pathology—with these benefits: relief of discomfort as spasm is relaxed, increased range mobility, faster return to more normal activiti

To relieve psychic tension when also pres
When psychic tension or anxiety complicates clinical picture of skeletal muscle spasm, the widely-recognized calming action of Valium m also contribute to total patient management.

(Artist's conception of reflex arc.)



fore prescribing, please consult complete oduct information, a summary of which follows:

dications: Tension and anxiety states; somatic nplaints which are concomitants of emotional tors; psychoneurotic states manifested by sion, anxiety, apprehension, fatigue, depressive nptoms or agitation; acute agitation, tremor, irium tremens and hallucinosis due to acute ohol withdrawal; adjunctively in skeletal scle spasm due to reflex spasm to local thology, spasticity caused by upper motor uron disorders, athetosis, stiff-man syndrome, nvulsive disorders (not for sole therapy).

ntraindicated: Known hypersensitivity to the g. Children under 6 months of age. Acute rrow angle glaucoma.

arnings: Not of value in psychotic patients. ution against hazardous occupations requiring mplete mental alertness. When used adjunctively convulsive disorders, possibility of increase in quency and/or severity of grand mal seizures y require increased dosage of standard anti- nvulsant medication; abrupt withdrawal may associated with temporary increase in frequency d/or severity of seizures. Advise against nultaneous ingestion of alcohol and other CNS pressants. Withdrawal symptoms have curred following abrupt discontinuance. Keep diction-prone individuals under careful rveillance because of their predisposition to bituation and dependence. In pregnancy, ttation or women of childbearing age, weigh tential benefit against possible hazard.

ecautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Valium® (diazepam)

2-mg, 5-mg, or 10-mg tablets, t.i.d. or q.i.d. and when skeletal muscle spasm and psychic tension interfere with sleep: add 1 tablet, h.s., to t.i.d. dosage

ROCHE

Roche®
LABORATORIES
Division of Hoffmann-La Roche Inc
Nutley, New Jersey 07110

Public Enema No.1





Claim the rewards of sparing your patients the tubes and tribulations of unpleasant enemas.

Compared to enemas, Dulcolax suppositories are a gentler and simpler way to empty the bowel. Gone are the tubing, the "accidents", and the bruised egos. Just one suppository, inserted against the bowel wall, usually brings about an evacuation within 15 minutes to an hour.

In the hospital, order Dulcolax for constipation or bowel cleansing. Your patients will often prefer it to embarrassing enemas. And you can be sure nurses will appreciate the saving in time and effort.

Dulcolax tablets taken at night usually result in a bowel movement the following morning. A combination of tablets at night and a suppository the next morning generally cleans the bowel thoroughly in preparation for surgery or special procedures. Keep in mind, however, that the drug is contraindicated in the acute surgical abdomen.

Dulcolax®...it's predictable

bisacodyl



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Geigy Pharmaceuticals, Division of Geigy Chemical Corporation, Ardsley, New York 10502

D 1

Alabamians Had Major Role In SMA Meeting

Alabamians played prominent roles in the 62nd annual meeting of the Southern Medical Association, in New Orleans.

Dr. Jon Vidalin Straumfjord, Jr., Birmingham, read a paper reviewing "experiences with multiphasic laboratory screening," was guest lecturer on "Commonly used heart and liver enzymes," and was one of three panelists discussing "Chemical Automation," including indications, hazards, interpretations, and quality control.

"Experiences with the Word Catheter in Management of the Bartholin Gland Duct" was the subject of Dr. Julian P. Hardy of Fairfield. Dr. Buford Word, who discovered the principle on which the catheter named for him works, is an SMA counsellor.

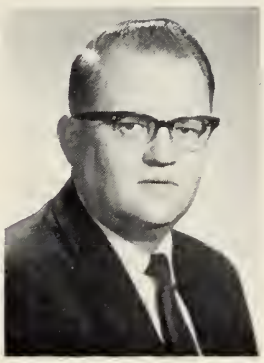
Dr. J. Garber Galbraith, Birmingham, is a past president of the Southern Medical Association, and presently a member of the SMA Board of Trustees.

The section on Medicine, of which Dr. Robert A. Kreisberg of Birmingham is secretary, had as its guest speaker Dr. Buris R. Boshell, professor of Medicine, Medical College of Alabama.

A paper on "Common Sense in the Selection of Drugs" was read by Dr. Sheridan W. Shirley, Birmingham, and a panelist for the discussion of "Gastrointestinal and Intra-Abdominal Bleeding" was Dr. Luther A. Longino.

Dr. D. Joseph Judge of Anniston, secretary of the Section on Pediatrics, was moderator for a panel discussion of "Surgical Emergencies in the Newborn"; Dr. Gilbert M. Kinzer of Huntsville is secretary-elect of the Section on General Practice; and Dr. Robert V. Barnett, Birmingham, is secretary of the Section on Obstetrics.

"Differential Diagnosis of Chest Pain" was the subject of a paper by Dr. T. Joseph Reeves of Birmingham, participating in a symposium on Cardiovascular disease.



Dr. Straumfjord



Dr. Word



Dr. Galbraith



The Clinical Research Center, whose responsibility is researching the unsolved problems of modern medicine, and which operates a hospital-within-a-hospital at the Medical Center, Birmingham, will be directed by Dr. Robert A. Kreisberg. He succeeds Dr. Clifton K. Meador, who in November was named dean of the Medical College.

ONE OF THE FEW BYLINES used in the revised **PHYSICIANS HANDBOOK** is that of Dr. Howard Lamar Holley of Birmingham, author of the terse history of The Medical Association of the State of Alabama, and who is presently writing a History of Alabama Medicine. Dr. Holley is appealing to his fellow physicians for all information that may be of value to the history, particularly "the minutes of early society meetings." All manuscripts and documents sent him will be preserved and returned to the owner by registered mail.

Jefferson Medical Society Installs Officers For 1969

New Officers elected by the 733-member Jefferson County Medical Society were installed at the Jan. 6th meeting of the Society.

Dr. Stephen L. Stigler advanced from president-elect to president, Dr. James A. Davis, Jr., moved from vice president to president-elect, and Dr. Walter F. Scott, Jr., was elected vice president.

Dr. Edward A. Harris, whose term had expired, was reelected to the Board of Censors; Dr. T. Albert Farmer, Jr., representative of the Medical College on the Jefferson Board of Trustees; Drs. Joseph L. Butler and H. Joseph Hughes, to the Mediation and Medical Ethics Committee; and the following to the Board of Trustees:

Drs. Gray C. Buck, Jr., Leon C. Hamrick, Julius N. Hicks, John M. Higginbotham, E. Rhodes Johnston, George E. Rudd, and, for the Bessemer area, John M. McMahon.

At the same time, from the Medical College of Alabama, the appointment of Dr. T. Albert Farmer to the new post of executive associate dean and director of undergraduate medical education was announced.

Members of the nominating committee for the Jefferson County Medical Society: Drs. William E. Lawrence, chairman; Lamar Campbell, Charles Neville, O. Thomas Bolding, John Harris, and Buford Word.



Dr. Stigler



Dr. Davis



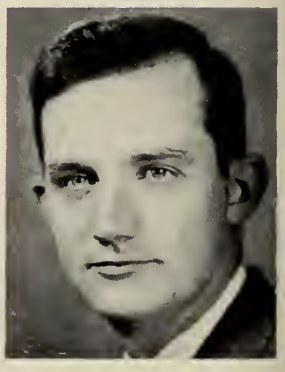
Dr. Scott



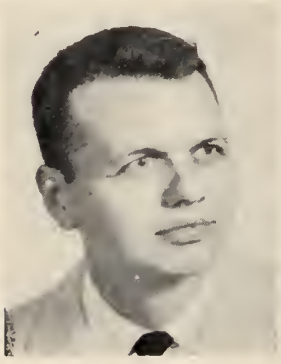
Dr. Harris



Dr. Farmer



Dr. Hughes



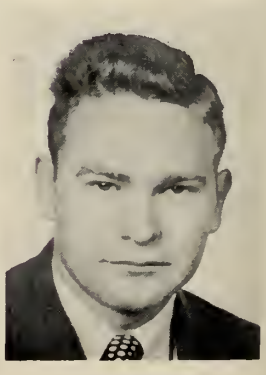
Dr. Rudd



Dr. McMahon



Dr. Buck



Dr. Hicks



roducing alginates to antacids

for a difference in taste you can feel

Derived from seaweed, and long used to impart velvety consistency to foods, alginates—a Warner-Chilcott contribution to antacid palatability—help 1) erase the chalkiness and grittiness found with some other antacids; 2) dispel unpleasant aftertaste. Like ice cream, Gelusil-M is smooth and creamy; and it has a cool mint flavor. Thus, for your patients Gelusil-M may be better to start on and easier to stay on.

introducing new GELUSIL®-M*

each 5 ml. teaspoonful contains:
500 mg. magnesium trisilicate
250 mg. aluminum hydroxide (Warner-Chilcott)
200 mg. magnesium hydroxide

*U.S. Patent No. 3,326,755

a consistent buffering anticostive† antacid

†Avoids constipation.

See next page for prescribing information ▶

GELUSIL–one name to remember...and a dosage form for every patient.



Gelusil®-M Liquid

especially for the constipation-prone patient

Indications: Gelusil-M is indicated for prompt and dependable symptomatic relief of peptic ulcer, gastritis, heartburn, hiatal hernia, esophagitis, and other conditions for which control of gastric hyperacidity is required.

Precaution: Prolonged or intensive therapy in patients with severe renal insufficiency may lead to hypermagnesemia.

Dosage: One to two teaspoonfuls (5 ml. to 10 ml.) between meals and at bedtime or whenever symptoms occur. Certain conditions, such as acute peptic ulcer, may require individualized dosage. If diarrhea occurs, reduce dosage or discontinue use.

Supplied: Gelusil-M (spearmint-flavored)—light green bottles of 12 fl. oz.; and a **special hospital pack.** Keep tightly closed—shake vigorously.

Gelusil® Tablets

the universal take-along antacid

Easy to take along / easy to take / pleasantly mint-flavored. An antacid with adsorbent and demulcent properties which contains in one tablet: 0.25 Gm. aluminum hydroxide (Warner-Chilcott) and 0.5 Gm. magnesium trisilicate (USP).

Dosage: 2 tablets—or more—between meals and at bedtime, or whenever symptoms occur. Tablets should be chewed.

Regular Gelusil® Liquid

when constipation is not a problem

Pleasant mint flavor...ideal for hospital or home. Available in 12 fl. oz. and 6 fl. oz. bottles and a special hospital pack. An antacid which contains adsorbent and demulcent agents in each 4 ml. teaspoonful: 0.25 Gm. aluminum hydroxide (Warner-Chilcott), 0.5 Gm. magnesium trisilicate (USP).

Dosage: 2 teaspoonfuls (4 ml. each)—or more—between meals and at bedtime, or whenever symptoms occur.

Also Available: Gelusil® Flavor-Pack, Gelusil-Lac®.

WARNER-CHILCOTT
Morris Plains, New Jersey
GM-IN-91-4C

Vital Statistics

NEW MEMBERS

Montgomery County

Pryor, Julius, Jr., b 24, mc Meharry 57, recip Ga. 59, 1156 Oak Street, Montgomery, Ala. 36108. S 269-2527.

Winston, John Henry, Jr., b 28, mc Meharry 56, recip Ga. 57, 1156 Oak Street, Montgomery, Ala. 36108. S 269-2527.

CHANGE OF ADDRESS OF MEMBERS

Cleburne County

Canup, Clarence N., present Heflin, Ala. 36264, to 3310 Henry Rd., Anniston, Ala. 36201.

Henry County

Johnson, Joseph W., present Abbeville, Ala. 36310, to Andalusia, Ala. 36420.

Jefferson County

Arnold, Sidney W., present Birmingham, Ala. 35233, to 1714 11th Avenue South, Birmingham, Ala. 35205.

Bearman, Alvin J., present Birmingham, Ala. 35206, to 3640 Dover Drive, Birmingham, Ala. 35223.

Collier, James B., present Graysville, Ala. 35073, to 3940 Forest Ave., Birmingham, Ala. 35213.

Colquitt, Charles J., present Bessemer, Ala. 35020, to 760 Gramon Drive, Bessemer, Ala. 35020.

Foy, Robert E., Jr., present Birmingham, Ala. 35233, to 400 North Edwards, Enterprise, Ala. 36330.

Givhan, Edgar G., Jr., present Birmingham, Ala. 35205, to 1025 South 18th Street, Birmingham, Ala. 35205.

Ippolito, Jerome G., present Bessemer, Ala. 35020, to P. O. Box 3361, Birmingham, Ala. 35205.

Ricketts, George L., Jr., present Birmingham, Ala. 35233, to Medical Arts Building, Birmingham, Ala. 35200.

Rountree, Walter B., present Birmingham, Ala. 35202, to 905 Carline Avenue, Birmingham, Ala. 35214—788-8341.

Shirley, Sheridan W., present Birmingham, Ala. 35223, to 1919-7th Avenue South, Birmingham, Ala. 35233.

Silberman, Donald J., present Birmingham, Ala. 35233, to 7000-5th Avenue South, Birmingham, Ala. 35212.

Lauderdale County

Jackson, Minter M., present Florence, Ala. 35630, to Box 798, Florence, Ala. 35630.

Lee County

Brantley, Joseph K., Jr., present Opelika, Ala. 36801, to 3018 Bryn Mawr Rd., Montgomery, Ala. 36106.

Madison County

Browning, Russell L., present Greenville, Tenn. 37743, to Brock Bridge Manor, Apt. 525, Ft. Meade Road, Laurel, Md. 20810.

Montgomery County

Byrne, Haynes C., present Montgomery, Ala. 36104, to 2185 Woodley Rd., Montgomery, Ala. 36111.

Hamner, Bennie R., present Montgomery, Ala. 36104, to 2900 McGehee Road, Montgomery, Ala. 36111.

Harris, Richard A., present Montgomery, Ala. 36104, to 2900 McGehee Road, Montgomery, Ala. 36111.

(Continued on Page 650)

So he'll breathe easier:

relieve anxiety while you relieve pain.

Relief of pain is usually a major goal in traumatic conditions. But often of importance, too, is alleviation of anxiety and tension that may heighten patient discomfort.

Single-prescription, non-narcotic Equagesic may effectively relieve pain. *And* ease anxiety and tension.

TABLETS

Equagesic®

(meprobamate and ethoheptazine citrate with aspirin) Wyeth®

IN BRIEF.

Contraindications: History of sensitivity or severe intolerance to aspirin, meprobamate or ethoheptazine citrate.

Warnings: USE IN PREGNANCY: Safety for use during pregnancy or lactation has not been established; therefore, it should be used in pregnant patients or women of child-bearing age only when the physician judges its use essential to the patient's welfare.

Precautions: Keep out of reach of children. Not recommended for patients 12 years old or less. Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use of meprobamate in susceptible persons—as alcoholics, ex-addicts, severe psychoneurotics—has resulted in dependence or habituation. Withdraw gradually after prolonged excessive dosage to avoid possibly severe withdrawal reactions including epileptiform seizures. Warn patients of possible reduced alcohol tolerance, with resultant slowed reactions and impaired judgment and coordination. If drowsiness, ataxia or visual disturbances (impairment of accommodation and visual acuity) occur, reduce dose. If symptoms persist, patients should not operate machinery or drive. After meprobamate overdose, prompt sleep, reduction of blood pressure, pulse and respiratory rates to basal levels, and hyperventilation are reported. Give cautiously and in small amounts to patients with suicidal tendencies. Treat attempted suicide (has resulted in coma, shock, vasomotor and respiratory collapse and anuria) with gastric lavage and appropriate symptomatic therapy (CNS stimulants and pressor amines as indicated). Two instances of accidental or intentional significant overdosage with ethoheptazine and aspirin have been reported. These were accompanied by CNS depression (drowsiness and lightheadedness) but resulted in uneventful recovery. On basis of pharmacologic data, CNS stimulation could be anticipated, with nausea, vomiting and salicylate intoxication (requires induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, and observation for hypoprothrombinemic hemorrhage [usually requires whole blood transfusions]).

Adverse Reactions: Ethoheptazine and aspirin may cause nausea with or without vomiting and epigastric distress, in a small percentage of patients. Dizziness is rare at recommended dosage. Meprobamate may cause drowsiness, ataxia and rarely allergic or idiosyncratic reactions. These reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses. Such patients may have had no previous contact with meprobamate and may or may not have an allergic history. Mild reactions are characterized by urticarial or erythematous maculopapular rash. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. If allergic reaction occurs, discontinue meprobamate; do not reinstitute. Severe reactions, observed very rarely, include fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. These cases should be treated symptomatically including, when indicated, such medication as epinephrine, antihistamine and possibly hydrocortisone. A few cases of leukopenia, usually transient, have been reported on continuous use. Rarely, aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia have been reported, almost always in presence of known toxic agents.

Overdosage: See precautions section for management of overdosage.

Composition: 150 mg. meprobamate, 75 mg. ethoheptazine citrate and 250 mg. aspirin per tablet.

Wyeth Laboratories Philadelphia, Pa.

Photo professionally posed.





VITAL STATISTICS

(Continued from Page 647)

Holding, Bruce F., Jr., present Montgomery, Ala. 36104, to 351 South Ripley Street, Montgomery, Ala. 36104.

Montgomery, Hubert T., Jr., present Fairfield, Ala. 35064, to 2119 East South Blvd., Montgomery, Ala. 36111.

Nolan, Thomas C., present Montgomery, Ala. 36104, to 2900 MeGehee Rd., Montgomery, Ala. 36111.

Penton, Robert S. B., present Rockford, Ala. 35136, to General Delivery, Millbrook, Ala. 36054.

Pugh, Walter H., present Montgomery, Ala. 36104, to 2900 McGehee Road, Montgomery, Ala. 36111.

Sullivan, John C., present Montgomery, Ala. 36104, to 2119 East South Blvd., Montgomery, Ala. 36111.

Thomas, Marcus C., present Montgomery, Ala. 36104, to 2900 McGehee Road, Montgomery, Ala. 36111.

Tallapoosa County

Shields, James, present Tuscaloosa, Ala. 35401, to 3301 Loop Road, Tuscaloosa, Ala. 35401.

Walker County

Simmons, John T., present Jasper, Ala. 35501, to P. O. Box 1365, Jasper, Ala. 35501.

NEW TELEPHONE NUMBERS

Leonard, Russell J., Anniston—236-6334

DEATHS

Tuscaloosa County

Kibbey, Richard Glenn, Jr., Bryce Hospital, Tuscaloosa, Ala. 35401—deceased November 19, 1968.



From the Washington Office
American Medical Association

Washington, D. C.—The incoming Administration work on a health program was started with President-elect Richard Nixon's appointment of John Dunlop, a Harvard University professor, to head a special task force.

Dunlop, 54, is a prominent economist and an expert in the manpower field. He has been a frequent adviser to the federal government since 1948.

In a letter to employes of the Department of Health, Education and Welfare, Secretary Wilbur J. Cohen, who will return to teaching at the University of Michigan, listed 13 health goals for the 1970s. He previously had said that his teaching position would leave him time to work for new and expanded health programs.

Most of the goals are non-controversial, and Cohen did not elaborate on details of implementation where controversy arises. The goals:—

—Continued expansion of medical research and more rapid dissemination of new knowledge to prevent and cure illness.

—Elimination of economic barriers to medical care, through comprehensive health insurance and other public and private programs.

—Major reduction in infant mortality and early childhood diseases.

—Elimination of malnutrition.

—Improvement in the organization and

delivery of medical care, with continued emphasis on high quality.

—Widespread transplantation of human organs and development of artificial organs.

—Expanded prevention and improved chances of recovery from heart disease, stroke, and cancer.

—Increase of health manpower and better use of professional skills.

—Elimination of large mental institutions and expansion of community mental health centers accessible to all.

—Family planning services available to everyone.

—Improvement in the quality of the environment, with major reduction in air and water pollution.

—Reduction of alcoholism, drug addiction, mental illness and mental retardation, and accidents.

—Elimination of smallpox, diphtheria, polio, whooping cough, and measles.

* * *

Developments in the drug field include starts on tests of an old drug in treatment of pneumonia and a new one for Parkinson's disease.

The National Institutes of Health started a wide-spread test of a polyvalent pneumococcal vaccine that was discarded 20 years ago with the entrance of antibiotics. Edwin M. Lerner, M. D., coordinator of the test program, said it had been demonstrated that persons die of pneumonia because of early stage damage and that antibiotics have not been a cure-all The old vaccine, manufactured by E. R. Squibb and Sons, was licensed and found effective in 1948, but was taken off the market in 1952 because of lack of sales.

"Penicillin was the cure-all in those days," Dr. Lerner said. "It was felt that there was no need to vaccinate people. After all, we thought we could cure them."

The Public Health Service announced a program to test an experimental drug in treatment of Parkinson's disease. Robert Q. Marston, M. D., Director of the National Institutes of Health said the drug, L-DOPA, may help "up to 75 per cent of patients." But he cautioned it has "serious and unpleasant side effects" which must be carefully checked.

Other developments in the drug field included:—

—The Pharmaceutical Manufacturers Association disputed the finding of an HEW Task Force on Drugs that a $41.7 million saving could have been obtained by use of generic instead of brand name products in 67 of the 409 prescription drugs used most often by elderly persons. C. Joseph Stetler, PMA president, said the claim was not documented and was based "on the unproven assumption that prescriptions written by generic name cost substantially less."

—A Food and Drug Administration Advisory Committee said that existing data on whether birth control pills can cause cancer of the cervix is still inconclusive. The Advisory Committee on Obstetrics and Gynecology repeated the recommendation of the World Health Organization that all women using birth control pills undergo six-to-12 month medical examinations.

—The government has drawn up a national drug system to permit computerized processing of drug data. The code is designed to provide the needed common language in which to communicate rapidly and accurately essential information about drugs. The code was drawn up by HEW and the Drug Trade Conference, which represents drug manufacturers and distributors.

Regional medical programs, a majority involving continuing education of physicians, are now underway in 24 areas, with 261 separate projects being carried out, according to a government report.

Thirty-one regions have not yet embarked on specific programs.

States and regions with the most listed pro-

jects to date are Tennessee (mid-South), 27; Missouri, 25; Texas, 24; South Carolina, 16; Intermountain (Utah, Wyoming, Montana, Idaho, Nevada), 16; Michigan, 15; Georgia, 14; Kansas, 14; Washington-Alaska, 4; Albany (N. Y.), 10; Memphis (Tenn.), 10; California, 9; Rochester, (N. Y.), 9; and, Oregon, 7.

* * *

The nation's largest mental institution, Saint Elizabeth Hospital, Washington, D. C., will be converted to a model of modern mental health services, training, and research by the National Institute of Mental Health.

The National Center for Mental Health Services, training, and research will be headed by Sherman N. Kieffer, M. D., Assistant Surgeon General of the Public Health Service.

The new national center will have three divisions. One is the Saint Elizabeth Hospital-Division of Clinical and Community Services. In collaboration with the D. C. Department of Health, this division will operate the area D Community Mental Health Center which includes much of Southeast Washington. It will also provide active treatment, care and rehabilitation services for the beneficiaries of Saint Elizabeth Hospital.

A division of intramural training will administer an expanded institute program to train new types of auxiliary mental health manpower and to test new training techniques.

The third division will be responsible for the development of new approaches in clinical research.

* * *

A deadly brain and skull defect was found in four of 14 aborted fetuses whose mothers used LSD, a George Washington University Geneticist reported.

Dr. Cecil B. Jacobson, reporting to a District of Columbia Medical Society meeting, said he also found "moderate" to "severe" flaws in chromosomes of "at least 50 per cent" of 75 female LSD users. The flaws are in genetic material and could impair offspring, he said.

Jacobson and his associates said they found their subjects by advertising in an underground newspaper for pregnant LSD users, "No Questions Asked." Among the group he has studied, he said, there were 22 normal births and 35 abortions, only 14 of which produced fetuses intact enough for study.

Four of the 14 had a disease called "exencephaly" which normally shows in less than one-half of one per cent of babies, he said. It is fatal, he said. One characteristic is that the brain is outside the skull.

Eighty per cent of the women studied were unmarried, Jacobson's aides said. Some had taken as little as one dose of LSD and others had taken it numerous times.

* * *

Man is threatened with self-destruction because he has damaged, ignored and contaminated "the earth that gives him life," according to a federal government official.

Charles C. Johnson, Jr., Administrator of the newly created Consumer Protection and Environmental Health Service in the Department of Health, Education and Welfare, said the threat—from pollution, unsafe food, drugs, water and chemical additives to food, —among other things—is increasing each year.

Johnson spoke at a symposium on Human Ecology. Ecology is the branch of science dealing with the relationship between people and their environment.

"With regard to the physical environment, we have reached, or at the very least are rapidly approaching, a critical point," Johnson told the gathering of scientists, lawyers, sociologists, engineers and other specialists.

"Every year, pollution gets worse, rather than better; the threat from unsafe food, drugs, water and a variety of consumer products is increasing; the quality of American life, particularly urban life, is deteriorating in a morass of environmental problems so complex as to appear almost beyond remedy," Johnson said.


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Effectiveness: DECLOMYCIN Demethylchlortetracycline should be equally or more effective therapeutically than other tetracyclines in infections caused by organisms sensitive to the tetracyclines.

Contraindication: History of hypersensitivity to demethylchlortetracycline.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enteroc pruritus ani. Skin—maculopapular and erythematous rashes; case of exfoliative dermatitis has been reported. Photosens onycholysis and discoloration of the nails (rare). Kidney—rise in apparently dose-related. Transient increase in urinary output, times accompanied by thirst (rare). Hypersensitivity reactions caria, angioneurotic edema, anaphylaxis. Teeth—dental stainin low-brown) in children of mothers given this drug during the latt of pregnancy, and in children given the drug during the neonata od, infancy and early childhood. Enamel hypoplasia has been s a few children. If adverse reaction or idiosyncrasy occurs, disco medication and institute appropriate therapy. Demethylchlo cycline may form a stable calcium complex in any bone-forming with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. S be given 1 hour before or 2 hours after meals, since absorp impaired by the concomitant administration of high calcium c drugs, foods and some dairy products. Treatment of strepto infections should continue for 10 days, even though symptom subsided.

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Each fluidounce contains: 80 mg. Benadryl® (diphenhydramine hydrochloride, Parke-Davis); 12 grains ammonium chloride; 5 grains sodium citrate; 2 grains chloroform; 1/10 grain menthol; and 5% alcohol.

An antitussive and expectorant for control of coughs due to colds or of allergic origin, BENYLIN EXPECTORANT is the leading cough preparation of its kind. BENYLIN EXPECTORANT tends to inhibit cough reflex... soothes irritated throat membranes. And its not-too-sweet, pleasant raspberry flavor makes BENYLIN EXPECTORANT easy to take.

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ADVERSE REACTIONS: Side reactions may affect the nervous, gastrointestinal, and cardiovascular systems. Drowsiness, dizziness, dryness of the mouth, nausea, nervousness, palpitation, and blurring of vision have been reported. Allergic reactions may occur.

PACKAGING: Bottles of 4 oz., 16 oz., and 1 gal.

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For a cold, NTz® Nasal Spray provides rapid relief of nasal symptoms. Relief starts with the first spray which opens the inferior part of the common meatus. A second spray, a few minutes later, will shrink the turbinates to help provide sinus drainage and ventilation. Dosage may be repeated every three or four hours as needed, for temporary relief of symptoms. NTz is well tolerated but overdosage should be avoided.

As a sinusitis deterrent, NTz Nasal Spray can be used to keep the nasal passages open during a cold to help prevent development of acute sinusitis—or to help prevent the acute condition from becoming chronic.

Supplied: NTz Nasal Spray, plastic squeeze bottles of 20 ml.; NTz Nasal Solution, bottles of 30 ml. (1 fl. oz.) with dropper.

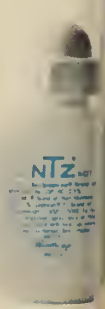
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Neo-Synephrine® (brand of phenylephrine) HCl 0.5 per cent, the major component, virtually synonymous with fast, efficient but gentle nasal vasoconstriction.

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Winth

Lister Steps Down From The Hill

Because the articulate son of an Alabama doctor went to Congress, the public in general and the medical world in particular have benefited, and as he retired voluntarily from his Senate seat, groups have come forward to accord him recognition.

To couch it in the more eloquent language of the citation presented him by the University of Pennsylvania, to accompany the honorary degree of Doctor of Laws:



Lister Hill

"The brilliant son of a distinguished surgeon, Lister Hill has advanced the cause of medicine through a series of extraordinary legislative enactments. It may be that, during his four decades in the Congress of the United States, he has done more for public health than any American."

The way *Medical World News* captioned a piece about him in its Nov. 1st issue was:

"Lister Steps Down From The Hill."

Long the acknowledged congressional leader in legislative attacks on the major problems of medicine, his accomplishments must headline:

The Hill-Burton Hospital and Health Center Construction Program, which has given the nation some 9,549 general hospitals, health centers, and other health and medical facilities of all kinds. In 1967 he introduced legislation to meet the needs of modernizing obsolete hospitals and other medical-care facilities. Legislation he fathered in 1965 utilizes the existing network of health facilities to mount an assault on heart disease, cancer and stroke through establishment of regional medical programs. The regional concept of the Hill-Burton Act brings facilities to the patients, providing the latest advances in medicine to victims of heart disease, cancer and stroke.

His influence has brought greatly increased support to medical research at the National Institutes of Health, the nation's medical schools and other research institutions into the cause and cure—and primarily the prevention—of cancer, mental illness, heart disease, cystic fibrosis, arthritis and rheumatism, cerebral palsy, and many other crippling and killing diseases, including the newly developing ones.

The Hill-Harris Act of 1963 is a legislative landmark in the fight against mental retardation and mental illness, helping to finance a comprehensive network of facilities for the mentally retarded and the mentally ill.

Other accomplishments under his legislative leadership include: expanded training and education facilities to provide more health and medical personnel; measures strengthening State and county public health units and their programs against tuberculosis, infantile paralysis, hepatitis, malaria, venereal disease, typhoid, diphtheria, whooping cough, tetanus, measles and other communicable diseases; and comprehensive rehabilitation legislation aimed at restoring the disabled and handicapped to active, useful lives.

Alabama is a leader among States taking advantage of the Hill-Burton program. All but two of Alabama's 67 counties now have hospitals, health centers, or other facilities built under the program. As of the first week in December, 1968, according to figures supplied by the Health Department's bureau of construction, the facilities completed in Alabama, under construction, or for which funds have been allocated, total 319.

In the recognition accorded Senator Hill may be listed the degree of LL. D. from ten universities, including Alabama and Auburn,

(Continued on Page 669)



Geigy



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chlorthalidone 50 mg.
reserpine 0.25 mg.

One Regroton tablet a day usually helps you and your patient bring high blood pressure down and keep it down.

Regroton produces a smooth, long-acting effect that usually reduces both systolic and diastolic pressures. At the same time it often acts to allay anxiety and nervous tension associated with hypertension.

Although Regroton is generally well tolerated, adverse reactions may occur. This drug is contraindicated in mental depression, demonstrated hypersensitivity, and most cases of severe renal or hepatic diseases. For a complete list of side effects, please see the Prescribing Information summarized on the following page.

Regroton®

chlorthalidone 50 mg.
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One Regroton tablet a day usually helps you and your patient bring high blood pressure down and keep it down.

Indications: Hypertension. **Contraindications:** History of mental depression, hypersensitivity, and most cases of severe renal or hepatic diseases. **Warning:** With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small-bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has frequently been required and deaths have occurred. Discontinue coated potassium-containing formulations immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Discontinue one week before electroshock therapy, and if depression or peptic ulcer occurs. *Use in pregnancy:* Because chlorthalidone may cross the placental barrier and appear in cord blood and thiazides may appear in breast milk, this drug should be used with care in pregnant patients and nursing mothers. When used in women of childbearing age, the potential benefits of the drug should be weighed against the possible hazards to the fetus. Use of chlorthalidone may result in fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult. Increased respiratory secretions, nasal congestion, cyanosis and anorexia may occur in infants born to reserpine-treated mothers. **Precautions:** Antihypertensive therapy with this drug should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents, other potent antihypertensive drugs, or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. To avoid hypotension during surgery, discontinue therapy with this agent two weeks prior to elective surgical procedures. In emergency surgery, use, if needed, anticholinergic or adrenergic drugs or other supportive measures as indicated. Because of the possibility of progression of renal damage, periodic kidney function tests are indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated. Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, the drug should be discontinued and potassium supplements given, provided the patient does not have marked oliguria. Take particular care in cirrhosis or severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Severe salt restriction is not recommended. Use cautiously in patients with ulcerative colitis or gallstones (biliary colic may be precipitated). Bronchial asthma may occur in susceptible patients. **Adverse Reactions:** The drug is generally well tolerated. The most frequent side effects are nausea, gastric irritation, vomiting, diarrhea, constipation, muscle cramps, headache, dizziness and acute gout. Other potential side effects include angina pectoris, anxiety, depression, bradycardia and ectopic cardiac rhythms (especially when used with digitalis), drowsiness, dull sensorium, hyperglycemia and glycosuria, hyperuricemia, lassitude, restlessness, transient myopia, impotence or dysuria, orthostatic hypotension which may be potentiated when chlorthalidone is combined with alcohol, barbiturates or narcotics, leukopenia, aplastic anemia, skin rashes, thrombocytopenia, agranulocytosis, nasal stuffiness, increased gastric secretions, nightmare, purpura, urticaria, ecchymosis, weakness, uveitis, optic atrophy and glaucoma, and pruritus. Eruptions and/or flushing of the skin, a reversible paralysis agitans-like syndrome, blurred vision, conjunctival injection, increased susceptibility to colds, dyspnea, weight gain, decreased libido, dryness of the mouth, deafness, anorexia, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Jaundice, xanthopsia, paresthesia, photosensitization and necrotizing angiitis are possible. **Average Dosage:** One tablet daily with breakfast. **Availability:** Pink, single-scored tablets in bottles of 100 and 1000.
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For details, please see complete prescribing information.

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Poison—Childhood Enemy Number One

Our children are poisoning themselves at the rate of nearly 1500 a day—and they're doing it while "safely" at home.

Each year, 500 of them die from the effects of a startling assortment of poison-packed products that can be found in any home. That's more deaths than are caused by polio, diphtheria, typhoid, scarlet fever and measles combined.

In fact, accidental poisoning at home is the most common emergency encountered by pediatricians, outranking falls, burns, sudden illness and all the other miscellany of medical problems common among children.

Public health officials point out that there is a widespread misconception among parents about what constitutes a poison. Consequently we have drifted into lethal living habits and as new labor-saving items go onto kitchen shelves, as new beauty aids are added to the dresser and as new drugs appear in medicine cabinets, the poisoning potential goes up.

The Public Health Service reports that about a quarter million products, designed for use in and about the home, contain toxins. Dangers lurk in a variety of common disguises and may even be hiding in the food cupboard. A few spoonfulls of ordinary table salt, for instance, can cause brain damage or death in an infant.

Admittedly salt poisoning is rare. Children can't abide much in the way of strong seasonings. But many household nonedibles seem to have a large appetite appeal for youngsters. Furniture polish, detergent, deodorant, medicine drops, even a few paint chips, well chewed, are among the many concoctions frequently sampled by young palates. The result is often a wild dash for the nearest stomach pump.

A Science feature article prepared by the Communications Division, American Medical Association.

The first really concentrated attempt to do something about poisons in the home came in 1927 with enactment of the federal Caustic Poisons Act. This law, at the time it became effective, set forth safety requirements for just 12 corrosive substances.

During the past decade broad new attacks have been made on the problem at the insistence of pediatricians, the American Medical Association and public health physicians.

Based on case studies and recommendations from these groups, the Hazardous Substance Labeling Act was signed into law by the President in 1960. The act endeavors to make household aids and medicines safer to keep around the house by requiring the label of such products to list poisons, antidotes and recommendations for use.

Doctors themselves have actively organized one of the most important advancements in the drive against self-poisoning—the poison control center. Here the poison contents of thousands of trade-name products are cross indexed. A call to any of these centers, located in hospitals across the country, will give a doctor the information he needs to help a youngster who may have unwisely imbibed from a bleach or perfume bottle.

At the request of the centers themselves, their work has been coordinated by the Department of Health, Education and Welfare which established the National Clearinghouse for Poison Control Centers in Washington.

Despite these efforts, both Congress and public health officials are well aware that there is no substitute for caution in the home. Informed, alert parents are the only real bulwark against the creeping increase in child poisonings, which average about a half million yearly.

"If I'd only known . . ." is the lament heard all too often from a mother who awaits word

from the emergency room about her poisoned child.

What parents should know is this:

* Cleaning and polishing agents, detergents, shoe polish, cosmetics, waxes, insecticides, paint, turpentine, petroleum-based products, wave lotions, chalk, bleaches, plant foods and sprays, plaster and thousands of similar items all may contain poison.

* Too much of virtually any medicine, even ordinary headache pills, can have toxic effects.

* A child's native curiosity will lead him to sample almost anything—even Christmas decorations, which often contain poisons. No child is safe in a room by himself, at least not for long.

A weekend report taken at random from the files of the New York City Poison Control Center illustrates what parents are up against when it comes to riding herd on junior's impromptu intake. Forty-nine reports concerning children were received that particular Saturday and Sunday. Of these five had swigged perfume and cologne, four tried laundry bleach, a like number tested baby powder and three coated their insides with paint. The individualists among them swallowed such things as corn remover, medicated salve, lighter fluid, and a wide variety of other substances ranging from deodorants to laxatives.

Case studies of such reports have a grim ring to them: A five-year-old girl spends ten days in the hospital after obligingly taking a teaspoon of dish washing powder offered by her two-year-old sister; a drink of kerosene nearly kills a Pennsylvania toddler; death comes swiftly to a little boy given a teaspoon of liquid from an old mineral oil bottle in which carbon tetrachloride was stored.

Not all poisons have to be swallowed to be deadly. A one-year-old child crawled through a puddle of insecticide spilled on the porch floor and absorbed a fatal dose through his skin. Two farm children were killed by a strong bug spray that passed into their bodies from a saturated burlap bag with which they were playing.

The intake of poisons carelessly stored in ordinary food containers is extremely high, occurring in about one-third of all cases involving children. They have killed themselves by consuming rat poison from a teacup, kerosene from a pop bottle, benzene from a milk bottle, bleach from a drinking glass and detergent from a cereal bowl. The contents of such utensils are automatically considered food by young minds.

Warning a child, even repeatedly, is not enough. For most poisonings occur among children under five—the age group with an undeveloped sense of danger. But there is nothing backward about their curiosity at this stage of life, and the ability of a child to first get about on his own is a sure sign that unaccountable things are going to start popping into his mouth. Two-year-olds are our number-one self-poisoners with one-year-olds close behind.

Medicines have a particular attraction. Perhaps it's because children want to mimic their parents, or perhaps they're just partial to tiny pills and little bottles. In any event, drugs left within reach of a child usually disappear quickly and account for 47 per cent of all poisonings.

Aspirin, a virtual staple in every home, is by far the favorite. It is the primary cause of poison deaths among children under five, according to a study by Dr. Matilda S. McIntire of the Omaha Poison Control Center. This drug in large doses can knock the delicate body chemistry out of balance causing heart failure, kidney damage or convulsions.

A spurt in unorthodox aspirin gobbling has coincided with the marketing of flavored tablets for youngsters. One little girl almost created an epidemic of aspirin poisoning single handedly. She staged a candy party for her young friends with flavored aspirin as the main delicacy. That particular party ended quickly in a hospital emergency room.

The wisdom of flavoring medicines has evoked mixed feelings among doctors. Some think they should be outlawed, others contend flavoring is helpful to get children to take medicine. Dr. Harold Jacobziner, Assistant Commissioner of the New York City Department of Health, reported that experience in the city's poison control centers would indicate "aspirin per se is the culprit and not the flavoring." Children, it seems, will eat most anything without regard to flavor, unless it happens to be the food that's best for them.

Barbiturates are another killer in the medicine cabinet. Actually the number of children who get among the sleeping pills, goof balls, yellow jackets, red devils, etc. is not high—probably because of the well publicized dangers. Incautious adults are by far the more frequent victims. The fact is that more people of all ages die from an overdose of barbiturates than any other medicine. And no wonder! More than 2,000 tons of this drug in various forms are sold each year in the United States.

Other potentially deadly medicines frequently pumped from the stomachs of youngsters include oil of wintergreen, digitalis, tranquilizers, liniments, laxatives and strong cough medicines.

Most accidents with medicine result from lackadaisical handling. The dresser top is no place for hair spray, nor is the wash stand a safe place for eye drops. Medicine cabinets are the best place for such things, since they are usually above the reach of children—unless your child happens to be an inveterate climber. Then special measures may be required.

Even those parents who keep drugs virtually under lock and key seem to forget that most poisons don't come in small bottles. Household supplies provide children with most of the poisons to which they fall victim.

In the average home there are more toxics stored at floor level in the kitchen than in any other room. A survey showed that 34 per cent of all poison mishaps occurred in the kitchen. It is the most deadly room in the house.

The cabinet under the sink and the broom closet are natural poison catch-alls—and natural places of intrigue for toddlers and crawlers. Into these accessible nooks go many of the 2,000 new home-use products that hit retail counters each month. The bright sales-appeal wrappers on most serve to further stir the inquisitiveness of the small fry.

If all this has you thinking that home is no fit place for a child, you might stop and consider that the outdoors isn't much better.

The growing season especially offers many hazards, for even the loveliest garden can be a booby trap. "Please Don't Eat the Daisies" should be taken literally. Many ordinary plants are poisonous—rhododendron, foxglove, elephant ear, mountain laurel, oleander leaves, castor beans, wisteria pods—and the use of garden sprays adds a deadly coating to those plants which aren't.

One of the deadlier elements to which children are particularly susceptible is lead. A high incidence of lead poisoning was found in a Chicago neighborhood where youngsters gathered to watch battery cases being burned and inhaled the fumes.

Other cases of lead poisoning frequently stem from eating paint chips and bits of plaster. One teething tot managed to poison himself by chewing on his crib, newly refinished with lead-based paint by his physician father. For this reason, most children's toys and furnishings produced in the United States are finished with lead-free paints. Some foreign manufacturers don't follow this practice.

The very commonness of many noxious items increases their danger. We grow careless as we handle them day after day. Some deadly products are in such widespread use that they are recommended for purposes for which they were never intended.

Carbon tetrachloride, fatal if either inhaled

or swallowed, was suggested as an oven cleaner by a national woman's magazine. The truth is, points out a New Orleans physician, that working in the confines of an oven with a rag saturated with carbon tetrachloride is courting swift death.

Even in a large room the vapors from this chemical can be highly poisonous. A South Carolina youngster, stretched out on the living room couch, nearly died because her mother was using carbon tetrachloride to clean a chair on the other side of the room. Many toxicologists have condemned its use in the home at all. Yet because of its effectiveness as a cleaner and solvent, it continues to be used as a dry shampoo, upholstery and window blind cleaner.

When it comes to poisons in the home experience isn't always the best teacher. Some children seemingly are poison prone. The number of repeaters in control centers files can be explained no other way. Among such children, the desire to explore with their stomachs overcomes any unpleasant memories of what happened the last time.

The mother of one set of twins found herself repeatedly calling the ambulance for her boys, who liked to dose themselves with moth balls, ant poison, etc. Nothing seemed to help until their father arrived home one day just in time to drive them to the hospital. The boys were bitterly disappointed. It seemed they liked the ambulances and sirens.

Every minute someone calls a poison control center somewhere to ask for help or report a poison mishap. While many of these centers have facilities for treating poison cases, this is not their primary function. The storing of vital information about poisons, antidotes and treatment procedure is. Hundreds of manufacturers are pouring new products for the home onto the market nearly every day; it is obviously impossible for anyone, even experts in toxicology, to keep track of all the hazards.

The poison control center idea was formulated by Dr. Edward Press, a member of the Accident Prevention Committee of the American Academy of Pediatrics. He organized the first center in Chicago in 1953 with the support of state and city health officials, the American Medical Association, the Federal Food and Drug Administration and the National Safety Council.

The plan proved an overwhelming success. Today similar control centers are in operation at more than 470 hospitals throughout the nation. Some are frequently called on for advice from overseas and from ships on the high seas.

The importance of having poisons listed by name on the bottle was illustrated by a little girl who proudly told her mother she had taken the "cold medicine" that was on the dresser. The horrified mother rushed the girl to the hospital, the medicine was actually eye drops. The eye drop bottle contained no label listing harmful ingredients and before they could be learned the little girl died. If doctors had known the poison, they would have had a fighting chance to save her life.

But parents frequently don't read labels and children usually can't. Labeling and control centers are fine in emergencies, but they are no substitute for a little care and shelf rearranging at home.

"From reports that come into the National Clearinghouse," said Henry L. Verhulst, its director, "there is no doubt in my mind that we would see a significant reduction in the number of cases of poisoning if parents would just get conscientious about their handling of home products and medicine.

"The statistics are firm. Between 65 and 70 per cent of all poisonings occur because an item was accessible to a child.

"If we're going to live in modern homes with modern conveniences and modern medicines, we have got to develop some up-to-date standards that will make home safe for our children."

Parents can lessen the danger from accidental poisoning if they'll keep in mind the following suggestions:

(Continued on Page 667)



This isn't the end of the line.

(New TUBEX® are constantly being added)



Only TUBEX® offers so complete a line of closed system injectables

and it's still growing.

To meet your present needs more precisely, the Tubex line comprises 37 different products in 69 dosage variations. And more are on the way.

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POISON—CHILDHOOD ENEMY NO. 1

(Continued from Page 664)

1. If you have reason to believe your child has taken a poisonous substance, call your doctor for instructions at once. Don't wait to see what happens.

2. Get the number of the nearest poison control center from your hospital and keep it by the telephone in case you have to learn in a hurry whether a substance is poisonous.

3. Take the suspected poison in its original container with you. This precaution can save your child's life.

4. Never assume a child won't eat or drink something that doesn't taste good. Keep drugs and household cleaners well out of his reach and make sure containers are sealed as tightly as possible.

5. Never transfer toxic materials from original containers; especially never store them in pop bottles, glasses, cups or bowls.

6. Wash contaminated utensils immediately and scrub your child's hands if he touches poisonous material.

7. Never leave a child alone when you're working with cleaners or other poisons.

8. Keep paint and plaster in good repair so a child can't nibble paint chips or plaster bits.

9. Give medicines only in a lighted room, and discard old medicines which are no longer being used.

10. When you throw away hazardous materials, be sure children can't reach the containers.

There's nothing new under the sun, and this includes the aches of arthritis. It was a common disease long before the Greek physician Hippocrates described it. Scientists now believe the hunched-over look of the caveman was due to arthritis. And many prehistoric dinosaurs were its victims. Skeletons show many of their huge bones grown together by arthritis.



Dr. Herbert V. Allen, current president-elect of the Mobile County Medical Society, will be the 1969 president of the society, with Dr. William T. Wright, president-elect; Dr. Gordon Carroll, secretary; and Dr. Samuel Eichold, treasurer. As Dr. Robert T. King becomes chairman of the Board of Censors, Dr. J. Richard Moore, Jr., joins the Board, filling the vacancy created by the rotation of Dr. H. M. Gewin from it.



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'Twas The Tree That Tottered And Fell!

Octogenarian who heard Jefferson Davis speak at Confederate Memorial Monument site laughs at age as he saws big trees into stovewood to give his neighbors.

Here's What Medical Science Threatens Most of Us With!

Methuselah lived to such an incredible age that to this day he is remembered. None rivals his claim to Biblical fame, but every generation has its examples of longevity—a way to fame that today, thanks to medical science, is being extended from the few to the many.

As we learn from example, some student of longevity might look into the case of James Yancey Brame, III, who once, perched on his father's shoulders, heard Jefferson Davis speak from the porch of the Alabama Capitol. This was 83 years ago April 28th.

The other day, when a friend, who is now with MASA, called on him at his College Court home in Montgomery, it was to find him perched in a tree. And being armed with a camera, it was no feat at all to get the picture of him there.

Foolhardy? Not at all, he will tell you. "I used to be a tight-rope walker in my younger days. Besides," he'll grin gently, "the only kind of inner-ear trouble I have calls for an ear-trumpet." He is as deaf as the proverbial post.

Days before the camera caught him up a tree, he had been in the topmost branches of this same tree, knotting one end of a heavy rope around the strongest limb. This rope was extended outward from the base of the tree and tied to a firmly planted stake, in the direction he wanted the tree to fall. Then he had tied buckets of stone and brick to the middle of the rope.

When the upper half of the tree fell as expected, he climbed down to the top of the ladder, down the ladder to the iron bench in which it was planted, and stepped nimbly to the ground. Incidentally, he rented a power saw to cut the 25-foot trunk remaining, and later to saw the tree into stove-wood length for his neighbors.

"He's going to hurt himself one of these days," predicts his "kid" brother, William Whitman Brame, who will be 86 years old next July 4.

—W. J. M., Jr.

LISTER STEPS DOWN FROM THE HILL

(Continued from Page 657)

and three Doctor of Science degrees from as many medical schools.

On Feb. 13th, a testimonial dinner given by Alabama Health and related organizations in Birmingham opened 1968's parade of accolades. A citation from the American College of Cardiology came on March 2nd, an Award from the American College of Physicians on April 4th, a Distinguished Alumnus Award from the Washington Chapter, University of Alabama Alumni Association, came May 22nd; HEW Award on anniversary of National Defense Education Act, of which he was co-author, Sept. 10th; named Honorary Fellow, American College of Surgeons, Oct. 17th; Meritorious Public Service Award, Veterans Administration, October; Abraham Flexner Award for contributions to Medical education, Association of American Medical Colleges, Nov. 2nd; Award for Contribution to American Education, Legislative Commission, NEA, Nov. 19th; special Albert and Mary Lasker Foundation Award, Nov. 21.

It was William S. White, columnist whose writings appear in many Alabama newspapers, who wrote of him in Harper's Magazine ten years ago:

"Countless millions owe their lives to Lister Hill. He has done more for the public health than any American in history."

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Warnings: Acute anaphylaxis (may prove fatal unless promptly controlled) is rare but more frequent in patients with previous penicillin sensitivity, bronchial asthma or other allergies. Resuscitative (epinephrine, aminophylline, pressor amines) and supportive (antihistamines, methylprednisolone sodium succinate) drugs should be readily available. Other rare hypersensitivity reactions include nephropathy, hemolytic anemia, leucopenia and thrombocytopenia. In suspected hypersensitivity, evaluation of renal and hematopoietic systems is recommended.
Precautions: In suspected staphylococcal infections, perform proper laboratory studies including sensitivity tests. If overgrowth of nonsusceptible organisms occurs (constant observation is essential), discontinue penicillin and take appropriate measures. Whenever allergic reactions occur, withdraw penicillin unless condition being treated is considered life threatening and amenable only to penicillin. Penicillin may delay or prevent appearance of primary syphilitic lesions. Gonorrhea patients suspected of concurrent syphilis should be tested serologically for at least 3 months. When lesions of primary syphilis are suspected, dark-field examination should precede use of penicillin. Treat beta-hemolytic streptococcal infections with full therapeutic dosage for at least 10 days to prevent rheumatic fever or glomerulonephritis. In staphylococcal infections, perform surgery as indicated.
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Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in m instances by proper dosage adjustment, b also occasionally observed at the lower do ranges. In a few instances syncope has be reported. Also encountered are isolated i stances of skin eruptions, edema, minor r strual irregularities, nausea and constipat extrapyramidal symptoms, increased and creased libido—all infrequent and genera controlled with dosage reduction; change EEG patterns (low-voltage fast activity) appear during and after treatment; blood crasias (including agranulocytosis), jaun and hepatic dysfunction have been repor occasionally, making periodic blood cou and liver function tests advisable during tracted therapy.

Usual Daily Dosage: Individualize for mum beneficial effects. *Oral*—Adults: M and moderate anxiety and tension, 5 or t.i.d. or q.i.d.; severe states, 20 or 25 mg or q.i.d. Geriatric patients: 5 mg b.i.d. q.i.d. (See Precautions.)

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FEBRUARY 1969



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of the

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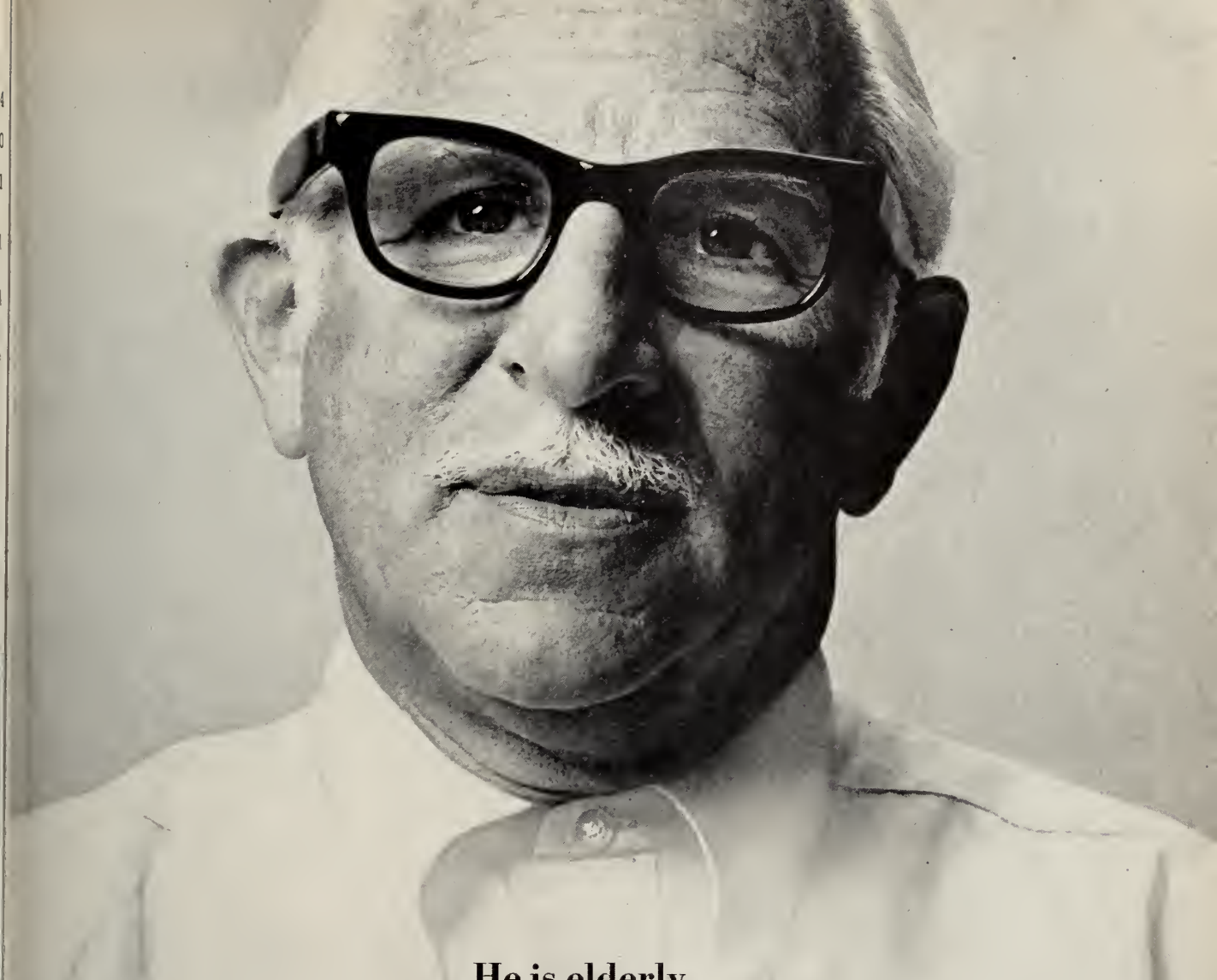
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'arning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses re indicated, and, if therapy is prolonged, serum level determinations ay be advisable. A photodynamic reaction to natural or artificial sunght has been observed. Small amounts of drug and short exposure may roduce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photollergic reactions have been reported. Patients should avoid direct xposure to sunlight and discontinue drug at the first evidence of skin iscomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

recautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken.

In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

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President's Page



E. L. McCafferty, Jr.

"God created order and the Devil created chaos. All this happened some years ago, but unwittingly or not, the Devil's Advocates are still with us."

Percy Hammond
1873-1936

During the past few weeks several changes in the top personnel of the AMA have taken place. A business consultant firm has been employed to make recommendations that will improve the effectiveness of the service that the AMA renders to its members and to the entire membership of the medical profession.

Over all it seems to me that the AMA has played an important role in promoting the many advantages that we as physicians enjoy today and it is hoped that under new leadership all of us will be able to recognize the results of the dedicated efforts of our officers and committees to develop an atmosphere in which we can as individual doctors practice our profession to the limit of our ability.

In Alabama we are fortunate in having Dr. John Chenault as a member of the Board of Trustees of the AMA. We can be assured that his interest and efforts will be directed toward protecting this liberty of practice.

Dr. E. Bryce Robinson has served for years on the Medical Education Committee and is especially valuable to us now that the need for enlarging medical education programs has been pointed out and publicized in Alabama.

Dr. M. Vaun Adams has been appointed as one of the evaluators of a Texas Medical School and in this capacity will gain knowledge that will be useful to us in promoting an expanded medical education program in our home state and will in time relieve the doctor shortage that is anticipated over the next few years.

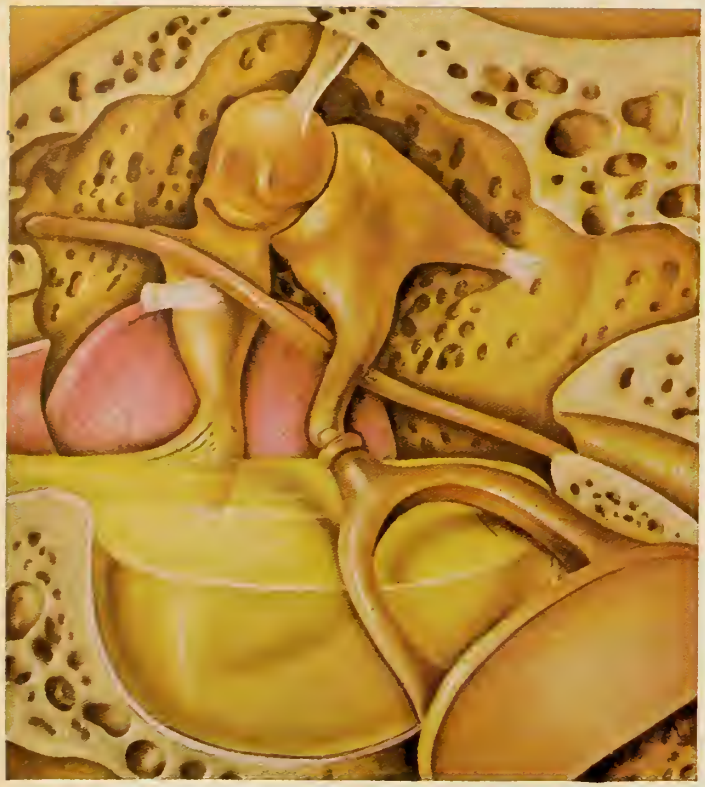
That the AMA has been instrumental in medical education, in the accreditation of hospitals and the dissemination of scientific information through its Journals and other publication goes without saying. AMA is probably the most important factor in the U. S., being recognized as the world leader in the medical sciences.

All of us are indebted to the AMA for its leadership in promoting our medical competency and for this reason, alone, should we feel obligated to support its objectives and to actively participate through our delegates in its programs.

There is another reason why we should be active members of the AMA and, to be purely

(Continued on Page 679)


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Contraindication: History of hypersensitivity to demethylchlortetracycline.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enter pruritus ani. Skin—maculopapular and erythematous rashes case of exfoliative dermatitis has been reported. Photoser onycholysis and discoloration of the nails (rare). Kidney—rise apparently dose-related. Transient increase in urinary outpu times accompanied by thirst (rare). Hypersensitivity reactior caria, angioneurotic edema, anaphylaxis. Teeth—dental stair low-brown) in children of mothers given this drug during the la of pregnancy, and in children given the drug during the neona od, infancy and early childhood. Enamel hypoplasia has beer a few children. If adverse reaction or idiosyncrasy occurs, disc medication and institute appropriate therapy. Demethylch cycline may form a stable calcium complex in any bone-formi with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. be given 1 hour before or 2 hours after meals, since abso impaired by the concomitant administration of high calcium drugs, foods and some dairy products. Treatment of strep infections should continue for 10 days, even though sympto subsided.

DECLOMYCIN®
DEMETHYLCHLORTETRACYCLINE

Capsules: 150 mg; **Tablets:** film coa mg, 150 mg and 75 mg of demethylch cycline HCl.

LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York

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heavenly relief
for unearthly cough

Benylin®
EXPECTORANT



Each fluidounce contains: 80 mg. Benadryl® (diphenhydramine hydrochloride, Parke-Davis); 12 grains ammonium chloride; 5 grains sodium citrate; 2 grains chloroform; 1/10 grain menthol; and 5% alcohol.

An antitussive and expectorant for control of coughs due to colds or of allergic origin, BENYLIN EXPECTORANT is the leading cough preparation of its kind. BENYLIN EXPECTORANT tends to inhibit cough reflex... soothes irritated throat membranes. And its not-too-sweet, pleasant raspberry flavor makes BENYLIN EXPECTORANT easy to take.

PRECAUTIONS: Persons who have become drowsy on this or other antihistamine-containing drugs, or whose tolerance is not known, should not drive vehicles or engage in other activities requiring keen response while using this preparation. Hypnotics, sedatives, or tranquilizers if used with BENYLIN EXPECTORANT should be prescribed with caution because of possible additive effect. Diphenhydramine has an atropine-like action which should be considered when prescribing BENYLIN EXPECTORANT.

ADVERSE REACTIONS: Side reactions may affect the nervous, gastrointestinal, and cardiovascular systems. Drowsiness, dizziness, dryness of the mouth, nausea, nervousness, palpitation, and blurring of vision have been reported. Allergic reactions may occur.

PACKAGING: Bottles of 4 oz., 16 oz., and 1 gal.

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A once-popular treatment for back pains was to have the seventh son of a seventh son stand or walk on the patient's back.



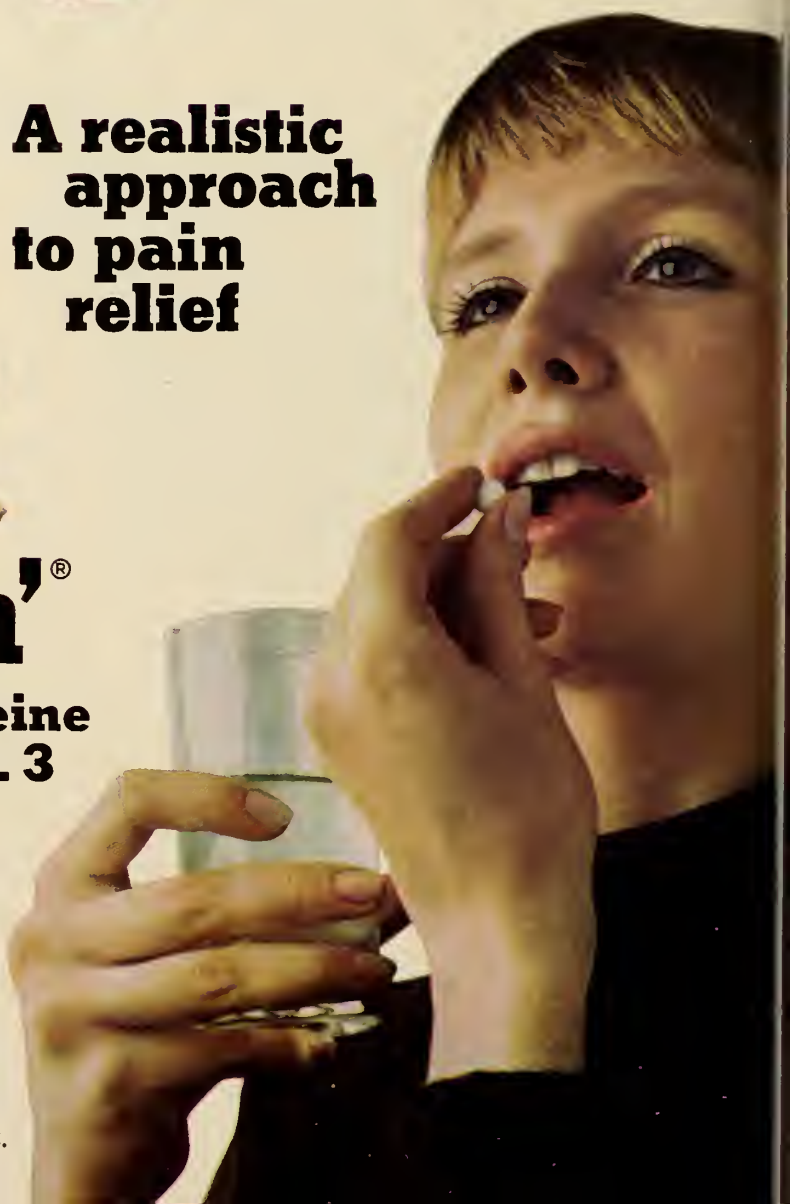


The pain of earache was allegedly relie by holding a hot roasted onion to the ea

For headache, a sovereign remedy was to wear a snakeskin round one's head.



A realistic approach to pain relief



'Empirin'®

Compound with Codeine Phosphate gr. 1/2 No. 3

Each tablet contains:
Codeine Phosphate gr. 1/2 (Warning—May be habit forming), Phenacetin gr. 2 1/2, Aspirin gr. 3 1/2, Caffeine gr. 1/2.

keeps the promise of pain relief

'B.W. & Co.' narcotic products are Class "B", and as such are available on oral prescription, where State law permits.

BURROUGHS WELLCOME & CO. (U.S.A.) INC.
Tuckahoe, N.Y.

(Continued from Page 674)

practical, may be an even more important reason than the scientific goals that medicine has achieved under its stimulus. That is the position of strength in unity which it affords in these changing times.

Most of us believe in changes to promote progress, and all of us are anxious to deliver the best medical care possible. However, the initiative, the incentive, and individual freedom of the profession must be protected. The AMA is the only organized body that can speak for us on a national level. Thus it behooves each of us to recognize our responsibility on a local, state and national level to participate in our political arena (ALAPAC and AMPAC) and attempt to guide the Federal programs in a way that we think through our experience as doctors and considered judgments as responsible citizens that will fulfill our obligations to society.

It is hoped that with the unbiased evaluation of the activities of the AMA a more effective and efficient organization will be developed. I'm sure that active participation by the individual members can promote an organization that will be stronger, more effective and can provide each of us with benefits in our day-to-day practice.

Let each of us understand that in an affluent society there is room for experiment that disturbs but does not seriously upset the established order. Our objective then should be to bind our united strength and good will toward an improved society under an orderly process.

The strength of the AMA depends on the efforts and support of each of us. During the formulation of a new congressional program changes will take place that will not only affect us now, but will affect our children, whether they be doctors or not, in the years to come.

E. L. McCafferty Jr.



The first 400 mg. Trocinate tablet usually relieves discomfort so promptly that Diarrhea ceases to be a bother

Trocinate has no known therapeutic value other than relaxing smooth muscle by direct action when coming in contact with the spastic muscle cell. Trocinate has none of the troublesome side-effects of anticholinergic drugs. Trocinate relieves the discomfort of diarrhea by decreasing both peristalsis and muscle tone. Trocinate is metabolized by the body and eliminated in the urine as harmless degradation products. Normal intestinal function is resumed.

The action of Trocinate is prompt, making the spacing of dosage easy. Often one or two 400 mg. tablets are sufficient to control diarrhea. The recommended dosage in spasm of the G. I. and G. U. tract is 400 mg. q. 4 h. A prescription of twelve (12) 400 mg. tablets will, in most cases, allow the patient to have a few to keep in reserve.

Literature and samples available

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The Woman's Auxiliary

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Southeast District Vice President, Mrs. George Andrews
Southwest District Vice President, Mrs. G. William Wiles
WAMASA Editor, Mrs. William L. Smith

AUXILIARY PLEDGE

"I pledge my loyalty and devotion to the Woman's Auxiliary to the American Medical Association. I will support its activities, protect its reputation and ever sustain its high ideals."



Mrs. Robert K. Wilson, Sr.

We are on the threshold of a new Year as I write this page. Looking back on 1968, I reflect on one of the busiest, most rewarding years that I have spent. I feel that I have benefited greatly from the experiences that have been mine, and I shall always be grateful for the opportunity of serving as President of WAMASA. I have a greater appreciation for the medical profession, the AMA, the Medical Association of the State of Alabama, and the organization that serves as its Auxiliary. As we approach 1969, let us resolve to use the time wisely, making every moment count, because there is much for us to do.

December has been a quiet month, travelwise. Early in the month, I met with the State Convention Chairman, Eloise Boone, and her committees, in Huntsville. These Auxiliary members have been very busy making preparations for the meeting in April and they are doing an excellent job.

The Archives and Exhibits Chairman, Jane Cameron, would like all the doctors who have unusual hobbies, or who are talented in painting, photography, or any type of creative activity, to participate in the Archives and Exhibits at the Convention.

No effort is being spared to make this an outstanding Convention, and we have much to look forward to. Besides the business sessions, there will be "added attractions" for the doctors' wives, and we hope that you will encourage them to attend, for knowledge, inspiration and pleasure.

Following the Convention planning meeting, I attended the Madison County Auxiliary meeting, a Luncheon meeting at the Carriage Inn, where the guest speaker was Mr. Millard Johnson, who is the administrator of one of the Huntsville hospitals. He will become the President of the Alabama Hospital Association in 1969. His message was a very thought-provoking one, in which he spoke of medicine as it will be practiced in 1990. He mentioned many changes which will take place in hospitals and in the practice of medicine in the future.

January will be a busy month, as I take up my travels over the state again. We have reached the half-way mark in this administration, and as I write a Newsletter to the Auxiliary Presidents in January, I shall ask them to take stock of activities, goals and projects in the local Auxiliaries.

For 1969, I wish for all of you a very rewarding, satisfying year.

Louise M. Wilson

(Mrs. Robert K. Wilson, Sr.)
President WAMASA

darkened street, or explores the unplumbed depths.

The word faith appears countless times in the New Testament, only twice in the Old.

Faith is a five-letter word that means many things to many people.

To the Book of Common Prayer it is "an outward and visible sign of an inward and spiritual Grace." To Walt Whitman it is "the antiseptic of the soul." To the "faith healer" it is a way to practice medicine without benefit of scientific knowledge. And to the modern doctor its synonym is "psychosomatic medicine."

Greatest of the famed trilogy—faith, hope, love—may be the last of the three, but the first is still faith.

Empty Purses May Halt Bus-Driver Robberies

Locked cash registers in Kress's, trained police dogs on guard duty in some of our bigger industrial plants, and now the company law against bus drivers carrying more than a few odd coins, are examples of how an aroused free-enterprise system is seeking to protect itself against a skyrocketing crime rate.

Just this week a member of the Medical Association staff boarded a bus in suburban Montgomery, offering a $1 bill. The bus driver looked, shook his head, and said: "Sorry, I can't make change."

"You mean, you're not allowed to make it."

"Both. I mean I'm not allowed to make change and am not permitted to carry enough change to make it."

In 1968 ten bus drivers over the nation were murdered in holdups. Drivers on the larger routes were carrying $50 to $100 to make change, and that was enough to attract the lawless, who reasoned sometimes that "dead men tell no tales."

Montgomery alone in 1968 experienced 37 robberies and attempted robberies of bus drivers, and several were slugged. All over Alabama and all over the nation, it was "open season" on them. The empty-purse order is the answer to it.

Montgomery is not alone in providing no change for bus passengers. Among other cities mentioned by veteran Bus Driver Marcus W. Ingram are Washington and Baltimore, Mobile and Jacksonville, Tampa and Charleston, and Atlanta. Birmingham, he said, is permitted to change no larger bills than $1, and this change consists of 50c cash and scrip for one additional bus fare.

Violence that flared during the bus boycott stopped Capitol City buses from night schedules, subsequently economies eliminated Sunday runs, and now passengers had best have the exact change when they board the bus in Montgomery and Mobile, and nearly the same in Birmingham.

Thus an empty purse may slam the bus door on crime in the streets.

And to complete the story of the MASA employe, in addition to the $1 bill, he had a silver quarter of the pre-phony minting days that he had hoped to save.

Alabama Loses Authority On Burn Treatment

Fire, one of the great challenges of human suffering, has provided through its victims, through the years, one of the great challenges to medical science.

A Montgomery surgeon who died in January, in less than ten years of practice had achieved a reputation for his treatment of fire victims that demanded his presence more and more when new patients with charred flesh were brought to intensive care.



Dr. Peterson

"Clinical Evaluation of Sulfamylon Acetate in Burn Treatment" was the subject of his report on Burn Research, conducted in cooperation with Sterling Winthrop Research Institute, of Rensselaer, New York.

James Clay Peterson, born in Whatley, Ala., Jan. 14, 1922, graduate of Holtville High School, Deatsville, with his baccalaureate from the University of Alabama and his degree in medicine from Louisiana State University, died on the eve of his 47th birthday.

In 13 years following his graduation from LSU's School of Medicine, Dr. Peterson interned at Charity Hospital, New Orleans; was in residency first at the U. S. Naval Hospital, Philadelphia, and then the Veterans Administration Hospital, New Orleans. He opened his practice in Montgomery July 1, 1959, performing general, thoracic, and vascular surgery.

A flight surgeon, he reached the rank of commander before leaving active duty, and was the attending doctor for the United States Marine Corps' reserve unit in Montgomery. A staff member of St. Margaret's, St. Jude's, Jackson, Montgomery Baptist, Elmore County Hospitals and the Tuberculosis Sanitarium, he was a past chief surgeon and past president of the staff at St. Jude's, he was also team physician for Catholic High School's football team, and past president of St. Bede's P-T A. His work with crippled children, with vocational rehabilitation, and Catholic charities was recognized.

A fellow of the International College of Surgeons and the American College of Surgeons, a Diplomate of the American Board of Surgery, active in his county, state and American medical associations, Dr. Peterson is survived by his widow, two daughters, three sons, his parents, the J. G. Petersons of Elmore; a brother, principal of a Fort Walton Beach, Fla., school, and a sister.

Tuberculosis? Influenza?
Pneumonia? Leukemia?
Hodgkin's Disease? Syphilis?
Systemic Fungal Diseases?
Chronic Chest Diseases?
or
HISTO?
(Histoplasmosis—"The Masquerader")



A new aid in differential diagnosis
HISTOPLASMIN, TINE TEST
(Rosenthal)
The LEDERTINE™ Applicator with the Blue Handle

Precautions—Nonspecific reactions are rare, but may occur. Vesiculation, ulceration or necrosis may occur at test site in highly sensitive persons. The test should be used with caution in patients known to be allergic to acacia, or to thimerosal (or other mercurial compounds).

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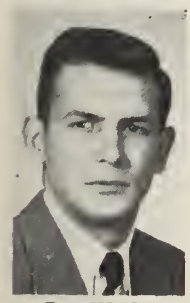
Ask your representative for details or write Medical Advisory Dept., Lederle Laboratories, Pearl River, New York 10965 406-8

Editorial Tribute Paid To Dr. John Wade

The day after his home town of Montgomery learned of the death of Dr. John F. Wade, Jr., The Montgomery Advertiser carried the following editorial written by Editorial Page Editor W. H. McDonald:

Dr. John Wade, who died Monday at age 43, was one of those genuinely fine human beings who qualify for the cliche, a prince of a fellow.

A skilled physician, he never lost sight of the human being behind all the clinical data. His warmth and friendliness were complemented by the same boyish grin he had when he played football for the Crimson Tide.



Dr. Wade

As it happened, we talked to him for some two hours, in December 1967, the night before he was to submit himself for tests which confirmed his informed suspicions about the disease that finally took his life.

The subject of the conference was the emergency room situation here and Dr. Wade was interested in our having all the facts. During the long discussion he showed no sign of apprehension as he explained the involute problems—medical, paramedical and financial—in that peculiarly engaging way of his—plain talk, punctuated by an occasional laugh at himself, exuding good will.

After the conference was over he casually mentioned what he faced, smiled and said: "I hope I'll be around awhile."

His self-effacing (almost self-deprecatory) manner might have had its origins in his being the unfortunate goat in the Sugar Bowl Game of New Year's Day, 1945. With the Tide leading in the closing minutes, Harry Gilmer took a deliberate safety, giving punter Wade a free kick from the 20. He had plenty of time. If the ball had gone anywhere near his usual distance, the Tide probably had the game on ice.

Wade unaccountably sliced the ball for short yardage. Duke went on to score and win the game.

Many were the times in recent years when friends, fellow doctors and patients alike, would twit him about that old misery: "How's the punting game going, John?" or a similar needle.

He would smile, reply something which indicated that the wound hadn't healed but he could laugh about it, and perhaps add: "I'm still working on it."

Several years ago we were in a hospital room when he had to tell a heart patient, then out of danger, what he could and could not do. It was a lucid explanation, but the strictures and regimen were hard to take and Dr. Wade knew it.

His stern lecture finished, his face broke into that broad, boyish grin and he extended his hand to the patient as he must have once to opposing players he had had to clobber.

"Friends?" he asked with a kind of giggle. "Friends," the patient replied, taking his hand, cheered that the doctor was a likable sort despite the unpleasant restrictions he had just delivered.

Dr. Wade's death in the prime of life is a tragedy to all fortunate to have known him. He was the epitome of the scholar-athlete who became an outstanding physician, devoted husband and father and a superlative person.

A past president of the Alabama Society of Internal Medicine, the 43-year-old doctor is survived by: his widow, Sara Jane McEachern Wade; his parents, Mr. and Mrs. John F. Wade, Sr., of Bridgeport; four daughters, Marsha Jane, Ann Elizabeth, Emily Carol and Sara Lynn Wade; and two sisters, Mrs. Jane Wade Winborne of Tuscaloosa and Mrs. Betty Wade Steckel of Lamoille, Ill.

Alabama Department of Public Health

Dear Members of the State Board of Health:

One of the major responsibilities of our profession is that of remaining informed. We must keep abreast of current developments which will better enable us to prevent, diagnose, and treat diseases and illnesses. This responsibility, however, imposes a major burden.

This principle can perhaps be best explained through use of a currently applicable illustration.

A recently marketed drug Talwin (brand of pentazocine) seemed to open new vistas to pain control without the harmful effects of addiction. A potent, well tolerated, synthetic analgesic copyrighted in 1967 by Winthrop Laboratories, this product was widely used as an effective substitute for morphine and other narcotic analgesics. As a result of extensive testing, the drug was not classified as a narcotic and was not subject to narcotic controls.

Routine investigations of records of physicians and pharmacists by narcotic investigators with the state health department's Division of Narcotics and Dangerous Drugs noted increasing usage of Talwin. In some instances abuse was suspected.

The credibility of these suspicions has been reinforced through an article published in the November 1968 issue of *Microgram*. This bulletin of the Bureau of Narcotics and Dangerous Drugs, U. S. Department of Justice reported:

> "Pentazocine (Talwin), is marketed as an analgesic. It has had publicity as a non-addicting drug, but no longer does the manufacturer make this claim. There are reports that Talwin is being abused, and that it may be addicting. We would appreciate reports on any instances of abuse, injuries or addiction coming to your attention."

Although new drugs such as Talwin are subjected to intensive tests prior to distribution, quite often unsuspected results can occur. This is not the result of inefficiency or inadequate testing methods, but more likely due to controlled testing conditions.

Physicians are afforded an excellent opportunity not only to pass the benefits of new and improved drugs and medications on to their patients, but also to detect adverse or potentially dangerous results which may be produced when used in a variety of situations and for prolonged periods of time.

Through fulfillment of this responsibility, you, as a practicing physician, can provide an invaluable service to your patients and to your profession. The observations of an alert practitioner may offer valuable clues to improved patient care and consumer protection.

Any observations, comments, or suggestions which will increase our knowledge about new or dangerous drugs are always welcome.

Sincerely,

Ira L. Myers M.D.

Ira L. Myers, M. D.
State Health Officer

BUREAU OF VITAL STATISTICS
PROVISIONAL BIRTH AND DEATH STATISTICS AND COMPARATIVE DATA

Ralph W. Roberts, M. S., Director

OCTOBER 1968

Live Births / Deaths / Causes of Death	Number Registered During October 1968			Rates* (Annual Basis)		
	Total	White	Non-White	1968	1967	1966
Live Births	5,555	3,758	1,797	18.2	18.7	18.9
Deaths	2,519	1,738	781	8.3	9.0	9.5
Fetal Deaths	103	49	54	18.2	18.6	22.7
Infant Deaths						
under one month	67	40	27	12.1	18.4	18.4
under one year	101	52	49	18.2	26.4	24.8
Maternal Deaths	1		1	1.8	0.3	3.5
Causes of Death						
Tuberculosis, 001-019	20	8	12	6.6	8.3	11.7
Syphilis, 020-029	4	3	1	1.3	1.7	
Dysentery, 045-048						0.7
Diphtheria, 055	1		1	0.3	0.7	
Whooping Cough, 056						
Meningococcal infections, 057	1	1		0.3	0.3	0.7
Poliomyelitis, 080, 081					0.3	
Measles, 085						
Malignant neoplasms, 140-205	387	280	107	126.8	125.9	138.4
Diabetes Mellitus, 260	55	36	19	18.0	18.2	14.4
Pellagra, 281						
Vascular Lesions of Central Nervous system, 330-334	359	241	118	117.6	127.2	134.4
Rheumatic Fever, 400-402					0.3	0.7
Diseases of the Heart, 410-443	831	620	211	272.2	290.2	312.6
Hypertension with heart disease, 440-443	81	41	40	26.5	29.7	35.4
Diseases of the arteries, 450-456	64	49	15	21.0	24.1	24.7
Influenza, 480-483					0.7	0.7
Pneumonia, all forms, 490-493	57	35	22	18.7	17.5	17.7
Bronchitis, 500-502	3	3		1.0	2.0	1.0
Appendicitis, 550-553	1		1	0.3	0.7	0.7
Intestinal obstruction and hernia, 560, 561 570	13	9	4	4.3	5.3	3.7
Gastro-enteritis & colitis, under two, 571.0, 764	3		3	1.0	1.3	3.0
Cirrhosis of liver, 581	20	13	7	6.6	10.6	6.4
Diseases of pregnancy and childbirth, 640-689	1		1	1.8	0.3	3.5
Congenital malformations, 750-759	21	12	9	3.8	4.1	3.4
Immaturity at birth, 774-776	25	13	12	4.5	4.6	5.7
Accidents, total, 800-962	179	135	44	58.6	65.1	73.2
Motor vehicle accidents, 810-835, 960	109	90	19	35.7	33.0	39.8
All Other defined causes	333	212	121	109.1	123.3	141.1
Ill-defined and unknown causes, 780-793, 795	141	68	73	46.2	54.2	46.1

*Rates: Birth and death—per 1,000 population
Infant deaths—per 1,000 live births
Fetal deaths—per 1,000 deliveries
Maternal deaths—per 10,000 deliveries
Deaths from specified causes—per 100,000 population

BUREAU OF LABORATORIES

Thomas S. Hosty, Ph. D., Director

December 1968

Examinations of Intestinal Parasites	1,461
Examination of Malaria	0
Examination of Salmonella & Shigella (blood-feces-urine-food)	270
Examination of tubercle bacilli	3,896
Examination of gonococci	1,409
Serological tests for syphilis	25,808
FTA	80
Darkfield	0
Brucella	0
General Bacteriology (cultures for isolation and confirmation)	11
Staphylococcus (cultures for isolation and confirmation)	10
Examinations for diphtheria (cultures for isolation and confirmation)	598
Streptococci examinations	3,301
Mycology	77
Agglutinations	5
Vincent's Infection	15
Complement fixation tests	250
Tests for Phenylketonuria (PKU)	6,637
Cytology	1,920
Water Examinations	*2,386
Milk and Dairy Products examinations	*4,146
Sea Food Examinations	160
Examinations for Negri bodies (smears & animal Inoculations)	294
Virology	14
Rh Factor Bloods	494
Special GC Study	1,109
Miscellaneous	1,976
Total	56,327

*Does not include Milk and Water Division of Central Laboratory.

BUREAU OF PREVENTABLE DISEASES

W. H. Y. Smith, M. D., Director

Current Morbidity Statistics

1968

	Nov.	Dec.	*E. E. Dec.
Tuberculosis	109	77	80
Syphilis	48	47	100
Gonorrhea	420	384	289
Chancroid	2	2	1
Typhoid fever	0	0	0
Undulant fever	0	0	0
Amebic dysentery	0	0	2
Scarlet fever & strep. throat	585	362	108
Diphtheria	2	2	5
Whooping cough	4	4	5
Meningitis	3	4	8
Tularemia	0	0	0
Tetanus	1	3	1
Poliomyelitis	0	0	1
Encephalitis	0	0	0
Smallpox	0	0	0
Measles	0	0	28
Chickenpox	10	24	53
Mumps	0	5	26
Infectious hepatitis	34	32	36
Typhus fever	0	0	0
Malaria	1	2	0
Cancer	754	391	606
Pellagra	0	0	0
Rheumatic fever	13	9	13
Rheumatic heart	18	13	24
Influenza	86	649	136
Pneumonia	300	302	241
Rabies—Human cases	0	0	0
Pos. animal heads	1	3	0

As reported by physicians and including deaths not reported as cases.

*E. E.—The estimated expectancy represents the median incidence of the past nine years.



The Month in Washington

From the Washington Office
American Medical Association

Washington, D. C.—A House Ways and Means Committee member introduced on the first day of the new Congress a bill that would provide federal income tax credits to help individuals buy private health insurance.

The legislation (HR 19), sponsored by Rep. Richard Fulton (D., Tenn.), was similar in principle to a health insurance financing plan utilizing tax credits approved by the American Medical Association House of Delegates at San Francisco last June and reaffirmed at Miami Beach last December.

Fulton said he considered his bill "at least an opener" for hearings.

"Certainly before expanding any federal program, I believe it worthwhile to explore the use of the private sector and our tax system," Fulton said.

The Fulton bill provides that individuals with incomes of $2,500 or less and families with incomes of $5,000 or less would receive $150 vouchers from the federal government per eligible individual for the purchase of health insurance. The family maximum would be $400.

In the case of a taxpayer with an income between $2,500.01 and $5,000, or a family with an income between $5,000.01 and $7,500, the credit would be a 75 per cent per eligible individual with a maximum of $400 per family.

In the case of a taxpayer with an income of $5,000.01 to $7,500, or a family with an income between $7,500.01 and $10,000, the credit would be 50 per cent per eligible individual with a $400 family maximum.

In the case of a taxpayer with an income exceeding $7,500.01, or a family with an income exceeding $10,000.01, the credit would be 25 per cent.

At San Francisco, the House of Delegates adopted as approved AMA policy "the principle of graduated income tax credits for premiums paid for adequate health insurance." A resolution adopted at Miami Beach called upon the AMA to "vigorously promote the enactment of federal legislation implementing" the plan.

* * *

A special commission on health facilities concluded that government and private enterprise must cooperate to organize the nation's health resources into effective, efficient and economical community systems of comprehensive health care for all persons.

The National Advisory Commission on Health Facilities, established in October, 1967, drafted its report to the President in general terms and did not make any recommendations for legislation.

James Z. Appel, M. D., a former president of the American Medical Association and a commission member, said the family physician would be the ideal "point of entry" to a community health system but there are not enough of them.

A summary of the report included:

"America's health care systems should combine private and public responsibility. Facilities and systems will vary from community to community in accordance with local capacities and local needs, but guiding principles should govern the effort to develop effective and efficient health care systems:

"1. These systems should be organized to assure appropriate points of entry into and continuity of health care services.

(Continued on Page 693)

"anorectal disorders"



This Rectopath Model
may help you explain certain anorectal disorders to some of your patients. It is yours on request.

See next page for details.

"anorectal disorder"

includes a range of problems. For symptomatic relief in some of these disorders consider a member of the Anusol Family...

One suppository morning and evening and after each bowel movement.

ANUSOL®

soothing, palliative relief of minor pain, itching, burning, and other associated discomforts.

Each ANUSOL suppository contains bismuth subgallate (2.25%), bismuth resorcin compound (1.75%), benzyl benzoate (1.2%), Peruvian balsam (1.8%), zinc oxide (11.0%), and boric acid (5.0%), plus the following inactive ingredients: bismuth subiodide, calcium phosphate, hydrogenated vegetable oil, and coloring in a cacao butter and white wax base.

One suppository morning and evening for 3 to 5 days.

ANUSOL-HC®

prompt reduction of inflammation plus the soothing effects of regular Anusol.

Each ANUSOL-HC suppository contains, in addition to the regular Anusol formula, 10 mg. hydrocortisone acetate.

Precautions: Prolonged use of Anusol-HC might produce systemic corticosteroid effects.

One suppository every 3 to 4 hours, or every 2 hours if symptoms are severe.

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-IN-91-4C

(Continued from Page 690)

"2. Every citizen should have ready access to quality health care.

"3. States, regions, local communities, and all health institutions should carry out continuous planning.

"4. Both those who provide and consume health services should participate in the decisions.

"5. All levels of health care should be interdependent."

* * *

A Health, Education and Welfare Department report to Congress recommended that preventive health care services not be added to medicare benefits at this time.

The report cited as reasons for the negative recommendation: administrative constraints, inability to estimate costs, limited experience with automated multi-phasic health screening, and an inadequate supply of health professionals.

The report was one of three requested by Congress last year and submitted before the change in Administration.

A second report dealt with coverage of mentally ill under medicare but did not include any recommendations.

The third reviewed qualifications of personnel under current medicare regulations. It stated that, because of an acute manpower shortage in the field, physical therapists should be considered qualified if they could establish an adequate level of competency. HEW is developing a proficiency examination.

HEW recommended against allowing licensed practical nurses to serve as nurses responsible for the total nursing care at an extended care facility. It also recommended against changes in the regulations that set minimal standards for independent laboratory personnel.

* * *

The premium rate for medicare supplementary insurance covering physicians' fees (plan B) will remain at the present rate, $4 each for the individual beneficiary and the federal government, until July 1, 1970.

The Johnson Administration's Secretary of Health, Education and Welfare, Wilbur J. Cohen, decided against an increase although the Social Security Administration's chief actuary had advised that an anticipated rise in physicians' fees called for an increase of 40 cents each for the beneficiary and the government.

Cohen again asked physicians to show "unusual restraint" in setting fees. He urged that physicians and patients cooperate "in eliminating unnecessary utilization of physicians services," and asked carriers and intermediaries to carefully review claims during the next 18 months.

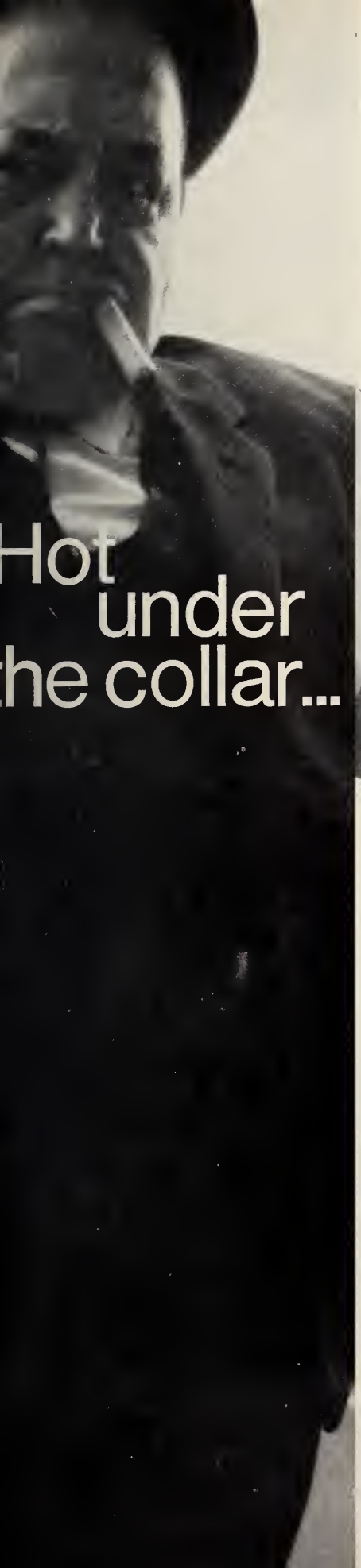
* * *

The Food and Drug Administration proposed that six widely prescribed antibiotic drug combinations be taken off the market on grounds that they fail to live up to their claims of effectiveness.

The drugs and their manufacturers: Albamycin G. U., Albamycin-T capsules and granules, and Panalba capsules, granules and drops—Upjohn Co.; Achromycin nasal suspension—Lederle Laboratories; Mysteclin F capsules, syrup and pediatric drops and Mysteclin F-125 capsules—E. R. Squibb & Sons Inc.

The drug companies were given 30 days to respond before FDA's final action. The FDA order could be appealed to the courts.

Two of the drug companies promptly protested the FDA proposal in public comments. An Upjohn spokesman said his company's combinations are superior to the major constituents alone. A Squibb spokesman said Mysteclin F had wide acceptance among physicians and a proper place in medical practice. A Lederle spokesman said Achromycin was not a major sales product, and declined to comment on what the company's official response would be.



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under
the collar...

high under
the cuff.

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he forgets he has hypertension, gets hot
under the collar...high under the cuff.

For such
patients, consider **Regroton®**

chlorthalidone	50 mg.
reserpine U.S.P.	0.25 mg.

To lower blood pressure
and allay anxiety in hypertension.

For brief summary of prescribing information, see next page.

RE-6392

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the once-a-day tablet for anxious hypertensives

Regroton is a combination of two basic antihypertensives designed to lower blood pressure and allay anxiety in hypertension. With Regroton he can keep his shirt on and you can keep his blood pressure down.

Before prescribing, please review carefully the indications, contraindications, warning, precautions, adverse reactions and dosage information below.

Regroton®
Each tablet contains:
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Indications: Hypertension.
Contraindications: History of mental depression, hypersensitivity, and most cases of severe renal or hepatic diseases.
Warning: With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small-bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has frequently been required and deaths have occurred. Discontinue coated potassium-containing formulations immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Discontinue one week before electroshock therapy, and if depression or peptic ulcer occurs.
Use in pregnancy: Because chlorthalidone may cross the placental barrier and appear in cord blood and thiazides may appear in breast milk, this drug should be used with care in pregnant patients and nursing mothers. When used in women of childbearing age, the potential benefits of the drug should be weighed against the possible hazards to the fetus. Use of chlorthalidone may result in fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult. Increased respiratory secretions, nasal congestion, cyanosis and anorexia may occur in infants born to reserpine-treated mothers.
Precautions: Antihypertensive therapy with this drug should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents, other potent antihypertensive drugs, or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. To avoid hypotension during surgery, discontinue therapy with this agent two weeks prior to elective surgical procedures. In emergency surgery, use, if needed, anticholinergic or adrenergic drugs or other supportive measures as indicated. Because of the possibility of progression of renal damage, periodic kidney function tests are indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated. Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, the drug should be discontinued and potassium supplements given, provided the patient does not have marked oliguria.
Take particular care in cirrhosis or severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Severe salt restriction is not recommended. Use cautiously in patients with ulcerative colitis or gallstones (biliary colic may be precipitated). Bronchial asthma may occur in susceptible patients.
Adverse Reactions: The drug is generally well tolerated. The most frequent side effects are nausea, gastric irritation, vomiting, diarrhea, constipation, muscle cramps, headache, dizziness and acute gout. Other potential side effects include angina pectoris, anxiety, depression, bradycardia and ectopic cardiac rhythms (especially when used with digitalis), drowsiness, dull sensorium, hyperglycemia and glycosuria, hyperuricemia, lassitude, restlessness, transient myopia, impotence or dysuria, orthostatic hypotension which may be potentiated when chlorthalidone is combined with alcohol, barbiturates or narcotics, leukopenia, aplastic anemia, skin rashes, thrombocytopenia, agranulocytosis, nasal stuffiness, increased gastric secretions, nightmare, purpura, urticaria, ecchymosis, weakness, uveitis, optic atrophy and glaucoma, and pruritus. Eruptions and/or flushing of the skin, a reversible paralysis agitans-like syndrome, blurred vision, conjunctival injection, increased susceptibility to colds, dyspnea, weight gain, decreased libido, dryness of the mouth, deafness, anorexia, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Jaundice, xanthopsia, paresthesia, photosensitization and necrotizing angiitis are possible.
Average Dosage: One tablet daily with breakfast
Availability: Pink, single-scored tablets in bottles of 100 and 1000.
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For details, please see complete prescribing information.

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Among the Newest Recruits of MASA's 50-Year Club

The year 1914, when the great-grandson of Alabama's first Episcopal bishop received his baccalaureate degree from the little Episcopal school in the mountains of Tennessee, the University of the South, was a landmark year in world history.

It was a year of crisis at home (as our fleet moved to exact an apology from Mexico for arresting a small party of United States Marines) and abroad (as the Triple Entente and the Triple Alliance collided head-on to launch World War I).

It was a year when Edgar Rice Burroughs and Vachel Lindsay became literary headliners (one with his *Tarzan of the Apes,* the other with his *The Congo and Other Poems*), when the death rate in the once fever-ridden Canal Zone dropped to less than half that of the continental United States, when an American chemist, Theodore William Richards, won a Nobel Prize for determining the atomic weight of elements, and when the marriage law of Wisconsin, based on eugenic principles, was declared unconstitutional.

It was five years later—another momentous year in United States and World history—when Beverly Woodfin Cobbs obtained his M. D. degree from Tulane University, to begin a career in medicine that would qualify him, half a century later, for admission to the Fifty-Year Club and recognition by the Medical Association of the State of Alabama.

This was a round decade before Wall Street's stock market collapse, in which the Great Depression was born, and a part of that decade was spent by young Dr. Cobbs in New York interning, first at Bellevue, later at St. Luke's. Thereafter he returned to his native Montgomery, was married to the late Esther Lee Rider, began the practice of medicine, and for some years was superintendent of the Tuberculosis Sanatorium. It was here that he pioneered in the collapse of lungs and sedimentation tests.

There are two children and four grandchildren in the family today. His daughter, the former Esther Lee Cobbs, is today Mrs. Lamar Rencher of Mobile. His son, Beverly Woodfin Cobbs, Jr., M. D., is today a resident of Atlanta, earning recognition in the field of cardiology.



Dr. B. Woodfin Cobbs

The senior Dr. Cobbs is married now to the former Bernice Crosby of Belfast, Maine, whom he knew in his intern days in New York.

Calendar of Annual Meetings

Medical Association of the State of Alabama

1969, April 24-26, Carriage Inn, Huntsville

1970, April 30-May 2, Mobile

1971, April 22-24, Birmingham

1972, April 20-22, Montgomery

1973, April 18-21, Mobile

It's almost as if you were there to give an injection of penicillin



V-Cillin K®, Pediatric dependable oral penicillin therapy

Potassium Phenoxymethyl Penicillin

Description: V-Cillin K, the potassium salt of V-Cillin® (phenoxymethyl penicillin, Lilly), combines acid stability with immediate solubility and rapid absorption. Higher, more rapid serum levels are obtained than with equal oral doses of penicillin G.

Indications: Streptococcus, pneumococcus, and gonococcus infections; infections caused by sensitive strains of staphylococci; prophylaxis of streptococcus infections in patients with a history of rheumatic fever; and prevention of bacterial endocarditis after tonsillectomy and tooth extraction in patients with a history of rheumatic fever or congenital heart disease.

Contraindication: Penicillin hypersensitivity.

Warnings: In rare instances, penicillin may cause acute anaphylaxis which may prove fatal unless promptly controlled. This type of reaction appears more frequently in patients with a history of sensitivity reactions to penicillin or with bronchial asthma or other allergies. Resuscitative drugs should be readily available. These include epinephrine and pressor drugs (as well as oxygen for inhalation) for immediate allergic manifestations and antihistamines and corticosteroids for delayed effects.

Precautions: Use cautiously, if at all, in a patient with a strongly positive history of allergy.

In prolonged therapy with penicillin, and particularly with high parenteral dosage schedules, frequent evaluation of the renal and hematopoietic systems is recommended.

In suspected staphylococcus infections, proper laboratory studies (including sensitivity tests) should be performed.

The use of penicillin may be associated with the overgrowth of penicillin-insensitive organisms. In such cases, discontinue administration and take appropriate measures.

Adverse Reactions: Although serious allergic reactions are much less common with oral penicillin than with intramuscular forms, manifestations of penicillin allergy may occur.

Penicillin is a substance of low toxicity, but it possesses a significant index of sensitization. The following hypersensitivity reactions have been reported: skin rashes ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; and reactions resembling serum sickness, including chills, fever, edema, arthralgia, and prostration. Severe and often fatal anaphylaxis has occurred (see Warnings). Hemolytic anemia, leukopenia, thrombocytopenia, and nephropathy are rarely observed side-effects and are usually associated with high parenteral dosage.

Administration and Dosage: Usual dosage range, 125 mg. (200,000 units) three times a day to 500 mg. (800,000 units) every four hours. For infants, 50 mg. per Kg. per day divided into three doses.

See package literature for detailed dosage instructions for prophylaxis of streptococcus infections, surgery, gonorrhea, and severe infections.

How Supplied: Tablets V-Cillin K® (Potassium Phenoxymethyl Penicillin Tablets, U.S.P.), 125 mg. (200,000 units), 250 mg. (400,000 units), and 500 mg. (800,000 units).

V-Cillin K® (potassium phenoxymethyl penicillin, Lilly), Pediatric, for Oral Solution, 125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc. of solution (approximately one teaspoonful). [042567A]

900134

Additional information available to physicians upon request.

Eli Lilly and Company, Indianapolis, Indiana 46206

Lilly

Table 1
raw data

case number	age	sex	mean length P wave	CMI score	case number	age	sex	mean length P wave	CMI score
13158	25	M	0.080	7	13180	24	M	0.080	4
13159	24	M	0.045	5	13181	23	M	0.075	6
13160	23	M	0.120	5	13182	25	M	0.070	4
13161	24	M	0.105	7	13183	23	M	0.090	2
13162	23	M	0.080	3	13184	42	M	0.080	28
13163	25	M	0.120	13	13185	37	M	0.100	1
13164	23	M	0.080	3	13186	22	M	0.080	27
13165	24	M	0.080	5	13187	23	M	0.080	2
13166	24	M	0.080	4	13191	28	M	0.080	6
13167	29	M	0.080	5	13192	23	M	0.080	3
13168	24	M	0.080	8	13193	25	M	0.090	7
13169	24	M	0.095	1	13194	28	M	0.080	4
13170	22	M	0.080	0	13195	24	M	0.080	0
13171	23	M	0.120	6	13196	23	M	0.080	1
13172	23	M	0.090	4	13197	26	M	0.080	8
13173	25	M	0.100	11	13198	23	M	0.080	20
13174	44	M	0.080	2	13199	27	M	0.080	7
13175	23	M	0.080	8	13203	22	M	0.080	7
13176	23	M	0.080	17	13204	23	M	0.080	6
13177	28	M	0.080	3	13205	24	M	0.070	5
13178	23	M	0.040	9	13206	37	M	0.100	36
13179	24	M	0.080	4					

from 0 to a high of 36. The mean and standard deviation are 7.3 and 7.6 respectively.

Results

It was pointed out earlier in young military personnel that the generally recognized range for P_1 duration, on the basis of careful physical examination, is 0.080 ± 0.018. A study of the pattern in these 43 subjects discloses very similar findings (0.084 ± 0.015 seconds).

It should be recalled that each of the subjects completed the Cornell Medical Index Health Questionnaire. On the assumption that fewer positive replies denote a healthier individual, the CMI scores were arrayed into three groups. The first subgroup, approximately one-third of the entire sample, was characterized by the fewest number of positive answers. Table 5 shows that 12 of the participants had less than 4 yeses on the questionnaire. By the same categorization technique, 11 subjects had more than 7 positive answers on the CMI. Assuming that Table 5 provides a relatively healthier and a sicker subgroup, it is appropriate to investigate the P wave duration. For the two samples, the means are the same (0.084 seconds).

Table 2
age distribution

age groups	number of subjects
20-24	28
25-29	11
30-34	0
35-39	2
40-44	2
total	43

Table 3

frequency distribution mean duration P wave [lead I]

P wave duration [seconds]	number of subjects
0.040	1
0.045	1
0.070	2
0.075	1
0.080	27
0.090	3
0.095	1
0.100	3
0.105	1
0.120	3
total	43
mean	0.084
standard deviation	0.015

Table 4

frequency distribution positive replies [CMI]

CMI scores	number of subjects
0- 4	18
5- 9	18
10-14	2
15-19	1
20-24	1
25-29	2
30-34	0
35-39	1
total	43
mean	7.3
standard deviation	7.6

However, the cluster about the mean is substantially different. Specifically, for the sickest it is 0.017 seconds; for the healthiest it is 0.000 seconds. This would tend to suggest that those with the fewest complaints are more alike with respect to this particular electrocardiographic parameter. Phrased another way, the evidence indicates that the subjects with the most complaints are more likely to exhibit a short or long P_1 wave duration.

Discussion

The traditional approach to the establishment of physiologic standards is to derive the mean plus one or two standard deviations of the parameter in question from a presumably healthy sample. The presumption is that 68 to 95 per cent of such a population may be regarded as within physiologic limits. Utilizing such a conventional statistical approach, the findings in the 43 dental students approach the recognized norms. However, physiologic electrocardiographic standards in a relatively symptomless and sign-free population are more restricted than those customarily utili-

Table 5

frequency distribution mean length P wave [Lead I]

mean length P wave	>7 CMI	<4 CMI
0.040	1	0
0.045	0	0
0.070	0	0
0.075	0	0
0.080	7	9
0.090	0	1
0.095	0	1
0.100	2	1
0.105	0	0
0.120	1	0
total	11	12
mean	0.084	0.084
standard deviation	0.017	0.000
significance of the difference of the means	$P > 0.500$	
variances	$P < 0.005$*	

*statistically significant difference

zed to delineate health and disease. These findings agree with those previously reported in dental practitioners and their wives [Cheraskin, Ringsdorf, Setyaadmadja, and Barrett, 1968].

Summary

1. Forty-three presumably healthy dental students participated in a study of the length of the P wave in a Lead I electrocardiogram.

2. By traditional statistical analysis, the findings are consistent with the recognized physiologic limits.

3. An analysis of the data in terms of the reported presence of general symptoms and signs as reflective of early marginal illness indicates that the groups with the least number of complaints show the least variation in P_1 wave duration.

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The Intensive Coronary Care Unit

F. Bernard Schultz, M. D. F. A. C. C.*

Auburn, Alabama

If I may requote Dr. Bernard Lown of Harvard University School of Public Health, "the coronary care unit makes increasing demands and augments physician responsibility," and as Dr. Eliot Corday, former president of the American College of Cardiology, stated a few years ago, "it means grabbing a tiger by the tail."

In these days of rapidly advancing public knowledge and the consciousness of the heart and the awareness of front page publicity of a former president's heart condition, the little two bed coronary unit which Dr. J. Roderick Kitchell and Dr. Lawrence E. Meltzer of the Philadelphia Presbyterian Hospital began with, together with the first coronary care unit in the United States, which was set up at Bethany Hospital by a Dr. Day in Kansas City, the intensive coronary care unit in the modern hospital today has graduated to special, specialized care for the coronary accident.

Many of our smaller community hospitals are planning intensive care units. It is hopeful that this comparatively short paper will be helpful to those of you who are contemplating such a venture. I recently attended a meeting of a small community hospital who were about to put out to sea. One of the staff members had obtained cost of equipment. The hospital administrator had found a couple of rooms in the hospital which he thought to be adequate. There did not appear to be any questions as to the source of money for the costs, who would be in charge of the unit, where the nursing personnel were coming from or who or where would they be trained.

One might ask, why an intensive coronary care unit? The primary factor is to prevent coronary fatalities. In the survey of coronary (acute myocardial infarction) deaths, it has been found in acute myocardial infarction, 47 per cent of the fatalities occur from arrythmias, 43 per cent from shock and congestion failure, eight per cent from emboli and two per cent from rupture of the ventricle, these are figures compiled from reconstructed data from the University of Pennsylvania Medical Center (The Presbyterian Hospital).

In another study by Drs. Hellerstein and Turell of Cleveland, they estimated in 82 fatalities of acute myocardial infarction, 42 per cent were the result of circulatory failure, 40 per cent from arrythmias and 18 per cent from a combination of circulatory failure and arrythmias.

In further studies and estimates, one must keep in mind, there are untold number of deaths from acute myocardial infarction that occur without hospitalization and/or before they reach a hospital. A rather constant figure in most hospitals, 18 per cent of all patients with acute myocardial infarction die 72 hours after admission. It is timely to state, these figures are common in hospitals whether there is or is not a house staff.

With the above data in mind, there is exacting evidence, and it is increasing; arrhythmic deaths are preventable. It is quite obvious, the physician cannot be in constant attendance. It is on this point where the nurse plays a stellar role. It is now generally known and accepted, the well trained nurse in coronary care, can now monitor an electrocardiograph, is able to begin treatment of

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defibrillation and pacemaking. In many cases, they have saved the patient's life. In looking over another set of figures, it was found (Presbyterian Hospital—Philadelphia) during a three year period, with a total admission to the intensive coronary care unit of 226, there were 46 incorrect diagnoses, leaving a corrected total of 180. Of these 180, ten per cent died within the first 72 hours. Only one death occurred from arrythmia, 11 died of shock, five died from shock and congestive heart failure and one from another cause.

We now come to the matter of the physical set up of an intensive coronary care unit in the hospital. How large should it be? Here we get into numerous questions, some silly, some profound. At this time there are probably 300 primary intensive care units in the United States varying in size from two to 16 beds. One hospital constructed a 32-bed unit but only 16 functioned.

Of great importance, before any construction begins, a thorough study of past and future needs should be carefully gone over. This will eliminate costly building programs. The medical and administrative staff must take time to talk with the architect and builder. There are very few architects and builders who know what is required in a coronary care unit. The electrician must provide ample, grounded outlets, prepare and have emergency power. The atmosphere must be cheery, the walls and ceiling sound proof and free access to and from. In the well functioning coronary care unit, a director of the unit should be appointed before the building begins. Like the chief of the fire department, who knows the types of fire fighting equipment, where the fire plugs should be, how to install an alarm and how to put out a fire; so should the director of a coronary unit go over the details of building and the type of equipment to be used. Of necessity and common sense, the unit should not be on the top floor of the hospital with only one elevator. It should be near, if one is available, to the intensive care facility and the emergency entrance of the hospital. This at times allows help to be obtained from those facilities, such as nursing personnel and orderlies. However, one thing to avoid is confusion. Needless to say the coronary care unit should be the quietest place in the hospital.

Nearly everyone is agreed on the type of equipment. Not as to its performance, but as to the service the manufacturer can give. There is the ever present question, the cost. It is most essential that the coronary care unit should be a unit within itself, it should provide private beds with lavatory for each patient. With this type of set-up, and equipment, the costs run between $1500 to $2000 per bed over the usual type bed cost. These figures include lighting and non-fluorescent spot lights, a central monitoring console, special communication systems, an alarm system for each bed, together with provisions to eliminate AC interference. Above all, avoid the equipment salesmen who try to sell you a hundred and one gadgets.

There are a number of "outside costs." The training of the nurses. Or for a physician to train the nurses, if the latter is available. If the nurses are sent to training centers—their salaries, travel expense, room and board must be defrayed.

How much is all this going to cost the patient? A few years ago, a survey throughout the country was about $60-$65, per day. Today, the figure is slightly higher. It is generally felt that this is a relatively small amount when you take into consideration that the patient has a private room, a skilled trained nurse (who usually takes care of only two beds) and highly specialized electronic equipment. Getting back to the unit director, he must have a clear cut understanding with the hospital administrator, that the patient will not be charged extra every time a special piece of equipment is used.

The question may be raised and should be raised relative to the medical supervision of a patient in a coronary care unit. This is fairly well controlled in a university hospital, with their chiefs, sub-chiefs, residents and long

established policies of who is going to do what. A different policy exists in the community hospital. In the opinion of many—the physician and patient relationship can remain unchanged and not create any friction, providing there are established policies made well in advance, before a coronary unit is established. Nevertheless, the private physician must surrender some of his responsibility to the unit director, especially in those cases where a complication of acute myocardial infarction needs immediate attention.

Any patient who has the ordinary, common run of the mill signs and symptoms of acute myocardial infarction should be immediately admitted to a coronary unit, be they a good or a poor risk. As to how long any given patient should remain in the coronary care unit is a matter of long debate. Personally, I agree with Dr. Unger of the University of Miami Medical School; the average stay in the unit being from five to seven days. This of course depends on the patient load and the size of the unit. These problems must be well thought out in advance.

One will ask, does a patient with congestive heart failure belong in an intensive coronary care unit? In this observer's opinion, the answer is no. It has been found that in acute circulatory failure, between 50-75 per cent die, regardless of the intensive care. In a well organized coronary care unit with specialized equipment, the specialized nurse training and their personal esprit de corps, a patient with acute congestive failure, fouls up the program. Further, the patient in acute congestive heart failure seldom develops ventricular fibrillation or stand still. While there is a certain amount of pessimism regarding the morbidity of circulatory failure, it is certainly felt that many of these patients can be saved. Primarily, if any developing arrythmia occurs it must be terminated. When Bradycardia develops—a pacemaker should be inserted. Of importance is the early recognition of failure, at the same time differentiating cardiogenic shock from hypotension. Sometimes this is quite difficult, however, a very useful method is a careful measurement of the urinary output in response to the rapid infusion of five per cent glucose. In hypotension there is usually a prompt increase in the amount of urine with a flow increase of 2 to 4cc per minute. In circulatory failure there is no urinary increase and oliguria occurs.

As to the treatment of shock; it may be said cardiogenic shock is the inability of the left ventricle to keep up the output, the stroke volume goes down and so does the arterial pressure. There is a question if peripheral resistance plays a role in this situation. If these are the facts, what should be done? 1. Improve left ventricular function, 2. Terminate any existing arrythmias and digitalization with ovabain. Probably the only other drug which is the most powerful inotropic agent is isoproterenol. There are other vasopressor agents but most of them induce arrythmias.

As a last thought, it might be well to say a few words relating to the medico-legal aspects which confront physicians and hospitals. To pose a question; should all hospitals have a coronary care unit?

There has been litigation where relatives of a patient who died sued both the hospital and the physician for inadequate care and facilities. It was presumed, the patient's life might have been saved, had there been a coronary care unit. Should a physician decide, the patient has a "slight" heart attack and also think he would spare the patient added expense for the services of the coronary care unit, the patient then develops a fatal arrythmia and dies; it could be decided, the physician showed poor judgment.

It is quite evident a physician must conform to the overall level of practice in his hospital and community. If one hospital in a given area has a coronary unit, and it is shown that mortality has been reduced because of that unit, certainly it behooves the other hospitals in that area to have a coronary care unit.

Acknowledgements

Dr. Schultz wishes to acknowledge and thank the many kindnesses, help and personal communications shown by Doctor Bernard Lown, Dr. Paul Unger, Dr. Peter Gazes, Dr. Thomas Killip, III, Dr. J. Roderick Kitchell and Dr. Lawrence Meltzer, also the staff and nursing personnel of the coronary care units of the Presbyterian Hospital, Philadelphia, the Abington Memorial Hospital, Michael Reese Hospital, Chicago, The Veterans Administration Hospital, Long Beach, California. Especially to, The Charles Press, 655 Eleventh Ave., New York City, for their excellent reproduction of "The Current Status of Intensive Coronary Care." This brochure is highly recommended to those physicians, hospitals and hospital administrators contemplating a Coronary Care Unit.

The following is a list of institutions (not too far from the State of Alabama) offering Coronary Care Nurse Training Programs, together with the name of the Project Director.

DISTRICT OF COLUMBIA
Catholic University School of Nursing
M. Lucille Kinlein, R. N.
600 Michigan Ave., N. E.
Washington, D. C. 20017

FLORIDA
Jackson Memorial Hospital
Adeline C. Jenkins, R. N.
1700 N. W. 10th Avenue
Miami, Florida 33136

Miami Heart Institute
Jonne E. Hicks, R. N.
4701 North Meridian Ave.
Miami Beach, Florida 33140

GEORGIA
Georgia Baptist Hospital School of Nursing
Kathryn Ransbotham, R. N. M. N.
300 Boulevard, N. E.
Atlanta, Georgia 30312

TENNESSEE
Baptist Hospital
Norma J. Shepard, R. N. B. S.
2000 Church Street
Nashville, Tennessee 37203

Saint Mary's Memorial Hospital
Patricia Cox, R. N.
Oakhill Avenue
Knoxville, Tennessee 37917

TEXAS
All Saints' Episcopal Hospital
Robert S. Capper, M. D.
1300 West Cannon Street
Fort Worth, Texas 76104

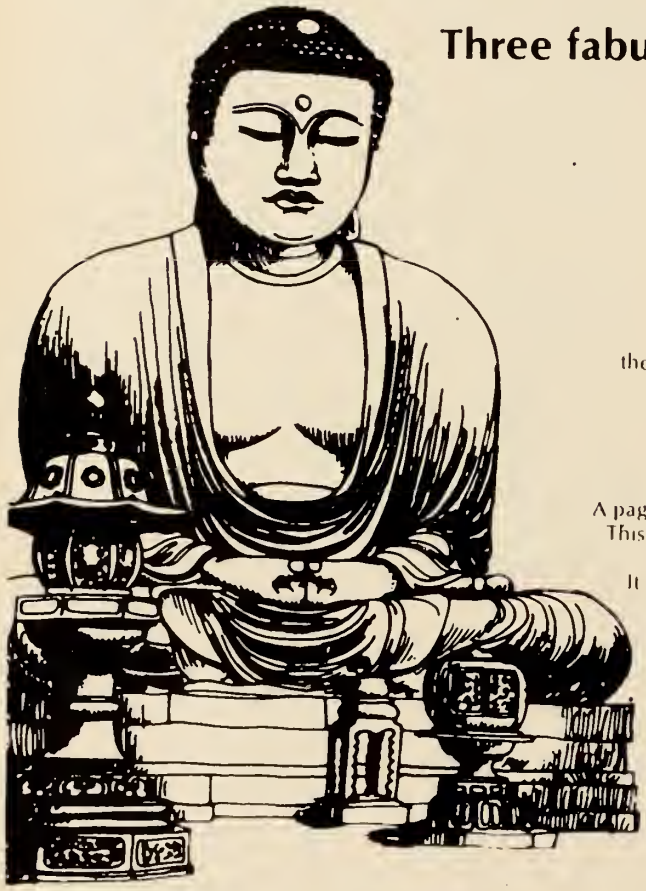
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Warnings: Lomotil should be used with caution in patients taking barbiturates and with caution, if not contraindicated, in patients with cirrhosis, advanced liver disease or impaired liver function.

Precautions: Lomotil is a Federally exempt narcotic with theoretically possible addictive potential at high dosage; this is not ordinarily a clinical problem. Use Lomotil with considerable caution in patients receiving addicting drugs. Recommended dosages should not be exceeded, and medication should be kept out of reach of children. Should accidental overdosage occur, signs may include severe respiratory depression, flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils tachycardia; continuous observation is necessary.

Adverse Reactions: Side effects reported wit Lomotil therapy include nausea, sedation, dizzines vomiting, pruritus, restlessness, abdominal discom fort, headache, angioneurotic edema, giant urticari lethargy, anorexia, numbness of the extremitie atropine effects, swelling of the gums, euphori depression and malaise. Respiratory depression an coma may occur with overdosage.

Dosage: The recommended initial daily dosage given in divided doses until diarrhea is controlle are as follows:

diarrheas...



- careful supervision
- electrolyte replacement
- specific anti-infective therapy

and...

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TABLETS/LIQUID

Each tablet and each 5 cc. of liquid contains:
diphenoxylate hydrochloride ..... 2.5 mg.
(Warning: May be habit forming)
atropine sulfate ..... 0.025 mg.

LOMOTIL, in conjunction with specifically indicated medical management, may be lifesaving in children with severe diarrhea.

Lomotil lowers the excessive intestinal propulsion characteristic of diarrhea. This reduction of precipitate intestinal flow allows a normal or more nearly normal reabsorption of fluid and electrolytes and counteracts the dehydration so hazardous to children.

Moreover, eight years' experience has demonstrated that Lomotil controls diarrhea with a minimum of unwanted secondary actions.

Senra del Valle and his associates[1] conducted a study of 477 children with diarrhea, most of whom were hospitalized with the disorder. Lomotil, used in 407 of the children, shortened the duration of the diarrhea.

Grinszpan, Goldstein and Divito[2] used Lomotil in 20 children with diarrhea and also reported a prompt disappearance of diarrhea. Harris and Beveridge[3] in a double-blind study of 50 children with diarrhea, however, found no clear pattern to suggest that Lomotil influenced the course of the condition.

Michener, Brown and Turnbull[4] added evidence supporting the beneficial effects of Lomotil in 80 children, concluding that Lomotil was highly useful in controlling abdominal cramping, diarrhea and hypermotility.

Children: Total Daily Dosage

3-6 mo. . . . ½ tsp.* t.i.d. (3 mg.)
6-12 mo. . . ½ tsp. q.i.d. (4 mg.)
1-2 yr. . . . . ½ tsp. 5 times daily (5 mg.)
2-5 yr. . . . . 1 tsp. t.i.d. (6 mg.)
5-8 yr. . . . . 1 tsp. q.i.d. (8 mg.)
8-12 yr. . . . 1 tsp. 5 times daily (10 mg.)
Adults: . . . . 2 tsp. 5 times daily (20 mg.) or 2 tablets q.i.d.

*Based on 4 cc. per teaspoonful.

Maintenance dosage may be as low as one-fourth the initial daily dosage.

References:

1. Senra del Valle, A.; Linfante de Rufinelli, E. B.; Brumetti, E., and Rossi, R. H.: El chlorhidrato de difenoxilato en las diarreas infantiles, Sem. Med. (Buenos Aires) *127*:475-484 (Oct. 4) 1965. **2.** Grinszpan, I. L.; Goldstein, A., and Divito, J.: El chlorhidrato de difenoxilato en las diarreas infantiles, Sem. Med. (Buenos Aires) *125*:758-763 (Aug. 27) 1964. **3.** Harris, M. J., and Beveridge, J.: Diphenoxylate in the Treatment of Acute Gastro-Enteritis in Children, Med. J. Australia *2*:921-922 (Nov. 27) 1965. **4.** Michener, W. M.; Brown, C. H., and Turnbull, R. B., Jr.: Ulcerative Colitis in Children. II. Medical and Surgical Therapy, Amer. J. Dis. Child. *108*:236-242 (Sept.) 1964.

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Legal Page:

Comprehensive Health Service Program In Lowndes County, Alabama

Public Law 88-352

Reginald T. Hamner, LL. B.

The first project to be initiated in a rural county in the United States under P. L. 88-352 and the 1966 amendment thereto has become operational in Lowndes County, Alabama. The additions made by Section 211-2 in 1966 make provision for Comprehensive Health Services Programs for the poor.

Administered under the Office of Economic Opportunity, the Comprehensive Health Services Programs are funded entirely by the federal government. This type program is separate and distinct from those programs for indigents under Title XIX or Medicaid. Responsibility for the funding of Medicaid (not yet implemented in Alabama) is shared jointly by the federal government and the state. Another significant difference in the two programs is the fact that Medicaid provides funds with no guarantee of services whereas under the OEO Program for health care, both the funds and services are provided.

Services available under the comprehensive health care programs include treatment, preventive health services, screening and diagnostic services, home care, case finding, rehabilitation, dental care and family services. Provisions are also made for the physical facility to be used in the program as well as the monies for the operation and equipping of such centers. Additional funds are available for training qualified persons to render services in the program and for salaries to employ persons trained under the training aspects of the program. Transportation to the care facility is provided for in the legislation.

Lowndes County, in the Alabama Black Belt, is 716 square miles in area. It has a population of 13,328 persons, 81.7 per cent of which is Negro. The fact that Lowndes County has one of the lowest per capita incomes of any county in the entire United States was a prime factor in its being selected as a county in which to initiate such a program. Approximately 80 per cent of the citizens of the county are qualified under the Alabama Title XIX standards.

The initiation of the program was resisted by the physicians in the county in principle when it was first proposed. When it became apparent that such a program was going to be initiated, the County Board of Health agreed to act as the sponsoring agency. The local initiative eliminated outside interest from establishing and controlling the program.

A planning grant in the amount of $53,055 was authorized the Lowndes County Board of Health to plan the project. A 17-member advisory board was created and Dr. Howard Meadows, a retired Navy medical officer and Lowndes County native was retained as the project director.

There are two practicing physicians in the county, one of whom is 79 years of age. The doctors are located in different parts of the county with one on the southern boundary and the other on the western boundary. During the first two months operation, the county had the services of two dentists and one druggist. The services of a third dentist have now been obtained. These six profes-

sionals are the providers of the services within the county under the program. The physicians and dentists under the OEO Program received in their contracts a usual and customary fee. One physician dispenses drugs and is salaried for this additional service. The lone druggist is paid a vendors fee in the amount of $1.65 per prescription. Both are compensated for the wholesale or G. S. A. cost of their drugs.

The initial attack in Lowndes County was three-pronged and became operational November 1, 1968. Presently included in the program is the provision of comprehensive medical care for the indigents, a training program for those qualified to assist in the program and the actual providing of jobs in the program itself. All three phases of this present program are funded from an original operation grant for nine months in the amount of $1,105,305.

Like many social welfare programs the end result and the projected good have not been the same. Practical problems involved in the implementation of the program in Lowndes County were not anticipated in the initial survey. The results available at the end of the first two months of operation are indicative of the impact such a program as the one in Lowndes County can have on the health professionals in a rural area.

As of December 31, 1968, persons registered under the OEO Program initiated in Lowndes County numbered 9,324. Of this number, 82.4 per cent were qualified under the criteria of the program and were certified for receipt of medical care. It is now anticipated that the final number to qualify will approximate 10,000. Qualification is based upon the income which is listed in a signed statement made by the applicant himself.

Those given cards are then free to obtain medical care from the two physicians in the county. The physicians in turn are under contract and receive their usual and customary fee for the professional services rendered, plus any charges for lab and X-ray work needed from the OEO by submitting their bills. Charge records are maintained upon each recipient at the physician's office. The OEO also seeks other data such as age and schooling level which is obtained at the physician's office. These records are maintained with the assistance of an OEO trained records clerk who is paid from OEO funds.

In those instances where more sophisticated treatment is needed and the need for a consultant arises, the local physician can refer a patient to the physician of his choice in one of the larger cities or towns for care. The consulting physician is then paid by OEO for his treatment. Emergency care is handled in much the same manner where the physician contacts the physician or hospital where the recipient goes for treatment. The hospital and attending physician in this, and in those other instances where hospitalization is required, are paid from the same OEO funds with Blue Cross-Blue Shield acting as the financial intermediary. The physicians' fees are again what is usual and customary.

During the first month of operation of the program in Lowndes County, the two physicians treated 1,228 patients together. Their combined totals for the month of December was 1,367 patients qualified under the OEO Program. The program in Lowndes County was projected to provide services for an anticipated 860-880 persons per month. Instead of the projected 20 patients per day per doctor workload, the first month's experience reflects an average load per doctor of 34 per day.

The dentist saw 404 patients during November and 508 during December while records for the two months show that a total of 1,431 extractions were made and 16 sets of dentures supplied. In addition to the corrective work done under the program, the dentist will begin a preventive dentistry program among school age children starting with those in the sixth grade. Upon completion of examinations in this group and corrective work, the fifth grade will be examined. It is anticipated with the arrival in June of a new dentist, that the preventive

program can be completed within three years.

The Alabama State Department of Public Health Maternity and Midwife Program is also being supported by the OEO Project. After the midwife files the birth certificate with the County Health Department, the midwife's fee is paid by the Community Health Project. In addition, in those instances where the patient is referred to a hospital by the County Health Department for a normal delivery, the OEO will pay this bill also. For any complicated delivery or complications of pregnancy the physicians will refer the patient to an obstetrician under the regular hospitalization program.

Plans have finally been approved for the construction of a clinic suitable for two physicians and one dentist in Lowndes County. Financing of the clinic is with 100 per cent federal funds. This facility has been held up for such reasons as controversies surrounding interior wall placement and ultimately the color to be applied to them. The plans have finally been approved.

The initial grant for professional service will not be sufficient to support the program and will be exhausted within seven months at the present pace. OEO has requested that no cutback be made in the services which would limit the patient load to that originally projected, 20 per day. Renegotiation of the contract for professional services has been promised. Additional funds are available in the program in other categories.

An overall evaluation of the program at this early date is impossible due to its short period of operation. It can be observed that it has moved along smoothly, though it is still short of providing all of the services planned. No transportation system is in use. Five vehicles are owned by the program; however, these are presently being utilized by public health nurses who make home visits in the county. Some persons have been receiving training under the program; however, their productivity has not been significant at this time.

What this program will mean to the citizens of Lowndes County in the future is academic at this stage. It is apparent that its effect on the members of the medical profession has been the thrusting of a monumental patient load on the practitioners there. It can be expected that the implementation of Title XIX will phase many of those presently receiving assistance under the OEO Program into it; however, again the problem still left to be resolved is where a sufficient number of physicians to care for these persons will come from. It is hoped that two general practitioners can be attracted to the county. The project director is prepared to offer good salaries. The Medical College of Alabama has consented to provide two residents on a two month rotation to implement the clinic. Plans also call for having consultants in all of the medical specialities visit the clinic on an as needed basis. The Medical College has also agreed to furnish consultants if their services cannot be obtained otherwise.

Two plus marks for the present program now in operation appear to be the facts that those physicians who have long rendered care are receiving some remuneration for their services rendered, and also the physicians are able to see those patients who formerly could not afford needed care receive hospitalization without having to be beneficiaries of some overtly charitable activity.

The physicians and other health professionals have set an example for all of the physicians in Alabama to follow. Though opposing the OEO Program in principle, they nonetheless did not relinquish the leadership responsibility in its establishment to others than their county society when it became apparent that the OEO Program would become a reality. It is essential that organized medicine continue to fulfill its rightful place of leadership in matters of public health.

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Warning: Activation of psychosis may occasionally be observed in schizophrenic patients. Do not use in patients under 12 years old, and do not use in women who are or may become pregnant unless the clinical situation warrants the potential risk.
Precautions: Careful supervision and protective measures for potentially suicidal patients are necessary. Discontinuation of therapy or adjunctive use of a sedative or tranquilizer may be necessary in the presence of increased anxiety or agitation, hypomania or manic excitement. However, phenothiazines may aggravate the condition. Atropine-like effects may be more pronounced (e.g. paralytic ileus) in susceptible patients and in those receiving anticholinergic drugs (including antiparkinsonism agents). Carefully observe patients with increased intraocular pressure. Prescribe cautiously in hyperthyroid patients and in those receiving thyroid medications. Cardiovascular complications (myocardial infarction and arrhythmias) are potential risks since they have occasionally occurred with imipramine, the parent compound. Desipramine may blo the pharmacologic activity of guanethidine and related adrene neuron-blocking agents. Hypertensive episodes have been obse during surgery in patients on desipramine therapy.
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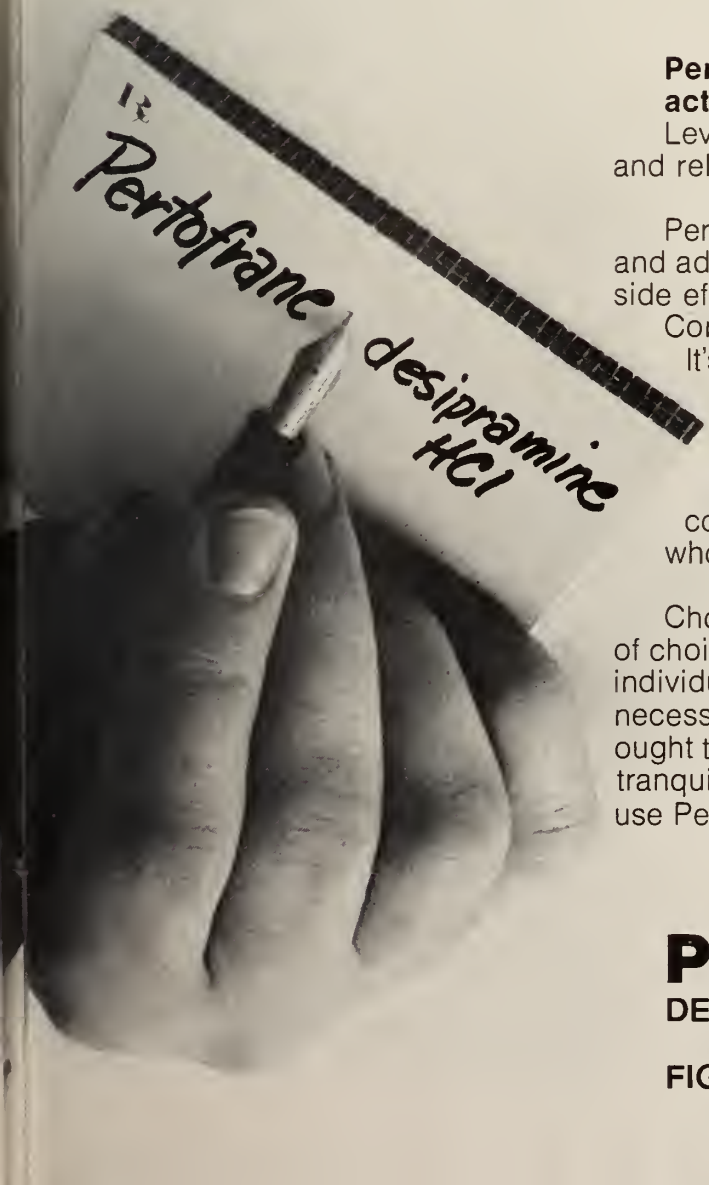
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The New Administration and the Business Outlook

W. L. Whiting, III

With the change in administration in coming years, it seems particularly timely to explore the general outlines of the new policy and the implications that government actions may have for the 1969 economic outlook.

Under the Nixon Administration the overall emphasis of economic policy will undoubtedly shift from Federal to private and state, and local spending and decision making. Yet despite the shift of emphasis to less Federal involvement, Mr. Nixon will accept the use of government action to balance the economy, especially to avoid recession. The economic policy may be somewhat less aggressive than it has been under the Johnson Administration, but it is still expected to be strongly anti-recessionary. Consequently, inflation will continue to be a pressing problem.

Although the new Administration's economic policy will influence the nation in coming years, it is expected to have few effects in 1969. At least several months will elapse before the Administration begins to take specific actions. It should be remembered that the initial budget for fiscal 1970, beginning in July will be prepared by the outgoing Johnson Administration. The new Administration will probably need time to develop satisfactory working relations with Congress, but Nixon's legislative program will be subject to compromise and accommodation.

Even if the Administration moves rapidly into high gear, no early change in fiscal policy is likely. The Administration, and certainly Congress, will want to wait until the much delayed effects of the surtax package are clearly evident before tampering further with taxes and Federal spending. The life span of the surtax itself seems beyond the direct control of the government. The tax surcharge will undoubtedly remain in effect until the Vietnam war is well on its way to a solution; the settlement date now appears to be more in the hands of the North and South Vietnamese than under the control of the Administration.

There is, however, one area where policy changes that will affect the 1969 business picture can still be made. That area is monentary policy, which is set by the semi-independent Federal Reserve Board.

At the moment, the state of the economy calls for continued monetary restraint. The foreign-trade surplus has collapsed in recent quarters as a result of domestic inflation, surging economic expansion, and rapidly growing imports. Despite a temporary lull, the international monetary situation remains perilous. The surtax has not yet reduced the accelerating rate of price and wage inflation. The Federal Reserve has responded by raising the discount rate to 5½ per cent while maintaining the interest rate ceilings on time deposits.

We believe that monetary policy will continue to be fairly tight for another quarter or two. But if, as we expect, economic growth slows perceptibly in the near future, the Federal Reserve will probably feel compelled to ease credit substantially early next year lest slower growth deteriorate into a recession. The discount rate may be dropped significantly from the new level.

Our forecast of easier money early next year is in line with the strong anti-recessionary tone that has recently typified monetary policy. Early in 1967 the Federal Reserve allowed the money supply to grow at an extremely rapid rate in an attempt to offset some of the depressing effects of the 1966 credit crunch. Furthermore, last summer the monetary authorities eased credit immediately after the surtax was passed, and before there was any evidence of its effectiveness, revealing extreme sensitivity to the possibility of excessive fiscal restraint and a resulting recession.

Next month's article in the Journal will discuss three critical components of the economy and how the new Administration may affect them.

Mr. Whiting is account executive for Merrill Lynch, Pierce, Fenner and Smith, Inc., in Mobile, Alabama.

Interesting One-Day Huntsville Medical Symposium Scheduled

Five fascinating subjects by as many prominent speakers will highlight the Huntsville Medical Symposium, co-sponsored by the Journal Club of Huntsville and the Alabama Chapter, American Academy of General Practice, scheduled for Thursday, Feb. 20th. The meeting will be held at the Carriage Inn.



Dr. C. E. Herlihy

After noon registration the program will open at 1:30 p. m. with a welcome address by Dr. Himon Miller, president of the Journal Club, and the business session will adjourn at 5 p. m. with cocktails scheduled for an hour and a half later, followed by a stag dinner.

"Improving the Results in Strangulated Intestinal Obstruction" is the subject of the opening speech, by Dr. William O. Barnett of Jackson, professor, Department of Surgery, University of Mississippi Medical School.

"Depression" is the subject of the second lecture of the day, by Dr. Charles E. Herlihy, associate professor, Department of Psychiatry, Medical College of Alabama, Birmingham.

There will be a 20-minute refreshments break at 3 o'clock, followed by a lecture by Dr. Herbert W. Birch, associate professor, Department of Gynecology and Obstetrics, Emory University, titled "Lesions of the Vulva and Vagina," followed by one at 4 p. m. by Dr. Judson Randolph, professor of surgery (pediatrics), chief of surgery, Children's Hospital, Washington, on "Intersex Problems."

Before adjournment for dinner there will be a question and answer period.

"The Current Status of Cardiac Valve Repair" will be the after-dinner subject of Dr. Charles A. Hufnagel, professor of surgery, Georgetown University.



Dr. W. O. Barnett

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How To Avoid The Grave

"Recent reports from medical schools indicate that the supply of unclaimed bodies for cadaver purposes is steadily declining," Ernest Morgan, Burnsville, N. C., writes in a letter addressed to the editor of The Journal of the Medical Association of the State of Alabama. "But for the increase in the bequeathal of bodies, the situation would be far worse than it is."

Further along in his letter, he adds: "It is interesting to note that some areas, including Alabama, are still experiencing serious shortages, whereas a few actually have a surplus. Some type of national clearing house appears to be the obvious answer. Another impending problem is the reconciling of the need for organs for transplant with the need for biological material for education."

He then proceeds to call the editor's attention to the attached booklet titled *A Manual of Simple Burial*, in the 64 pages of which he discusses, in deadly seriousness, such subjects as "The Significance of Simple Burial," "The Need for Advance Planning," "Needs at Time of Death," "Simple Burial and Trade Unions," "Eye-Banks" and "Temporal Bone Banks," "How to Bequeath your Body" and "How to Bequeath your Eyes," and a variety of other subjects, all for the price of $1.

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introducing an anticostive* antacid

*Avoids constipation.

an antacid formulated especially for the constipation-prone patient

- Gelusil-M has been formulated to help avoid constipation in these patients: hospitalized/bedridden/debilitated/sedentary/pregnant/elderly/on a bland diet/on anticholinergic-antispasmodic drugs/when straining at stool should be avoided.
- Magnesium content helps maintain intestinal fluid volume and motility.
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introducing new

GELUSIL®-M*

each 5 ml. teaspoonful contains:
500 mg. magnesium trisilicate
250 mg. aluminum hydroxide (Warner-Chilcott)
200 mg. magnesium hydroxide

*U.S. Patent No. 3,326,755

a consistent buffering anticostive† antacid

†Avaids constipation.

See next page for prescribing information ▶

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especially for the constipation-prone patient

Indications: Gelusil-M is indicated for prompt and dependable symptomatic relief of peptic ulcer, gastritis, heartburn, hiatal hernia, esophagitis, and other conditions for which control of gastric hyperacidity is required.

Precaution: Prolonged or intensive therapy in patients with severe renal insufficiency may lead to hypermagnesemia.

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the universal take-along antacid

Easy to take along / easy to take / pleasantly mint-flavored. An antacid with adsorbent and demulcent properties which contains in one tablet: 0.25 Gm. aluminum hydroxide (Warner-Chilcott) and 0.5 Gm. magnesium trisilicate (USP).

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Year of Promise Looms on 1969 Horizon

By Anita Smith

News Staff Writer

(Reprinted by Permission)

A year of achievement and planning, of problems and tragedies, and finally, of promise was seen in Alabama's health picture during 1968.

Achievement showed itself in the form of new techniques, new faces, and new buildings to keep Alabamians healthier.

May 8, 1968, saw the state's first kidney transplant surgery performed. A team of surgeons from the University of Alabama Medical Center performed the transplant surgery at Birmingham's Veterans Administration Hospital.

Since then, several other kidney transplants have been performed at the Medical Center.

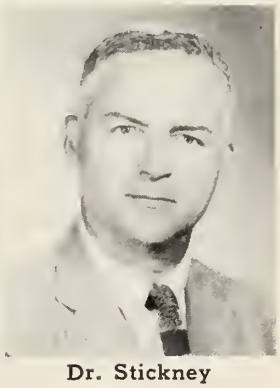
On Nov. 29, 1968, a urologist at Carraway Methodist Hospital in Birmingham removed a cancerous prostate gland from an elderly male patient by freezing the gland with liquid nitrogen.

First Time Here

This was the first time in Alabama that a prostate had been removed utilizing the freezing technique.



Dr. Alphin



Dr. Stickney

In September, 1968, Dr. Stonewall Stickney became a welcome new face in Montgomery, when he came to Alabama to become director of the Alabama Department of Mental Health.

The 45-year-old psychiatrist represented the end of a search by the Alabama Board of Mental Health for someone to head the state's mental health program.

A native of Selma, Dr. Stickney returned to

Alabama from Pennsylvania, where he was director of mental health services for Pittsburgh public schools.

(Dr. Thomas H. Alphin, 53-year-old native Virginian, became Medical Director for the Title XIX program in Alabama on May 27th, last year, appointed by the State Committee of Public Health. He came to Alabama from New York, where he was medical director and vice president of Equitable Life Assurance Society.)

The entire year was sparked by one of the biggest health building booms in the history of the state.

For example, the end of 1968 saw construction under way on ground broken for well over $40 million in buildings at the University of Alabama Medical Center.

Much Construction

Among these projects is the much-discussed Mercy Hospital, a project of the Jefferson County Commission; the North Central Alabama Rehabilitation Center, a project of the Alabama Society for Crippled Children and Adults; additions to Children's Hospital and to Eye Foundation Hospital. Projects of those individual private hospitals; and a Basic Science Building, a School of Nursing Building, a Medical Center Library, a Computer Center, a regional technical institute, and additions to Spain Rehabilitation Center and to University Hospital, all projects of the University of Alabama.

At the same time that notable health achievements were being made, plans were being laid for health achievements of the future.

For example, the word "Medicaid" was heard repeatedly during the year, as Alabama made final plans for the 1969 implementation of this vast multi-million-dollar health program in 1969.

"Medicaid" is a federal-state matching program to finance much of the health care for the blind, the disabled, those receiving old age assistance and aid to dependent children —and in years to come, for all the State's medically indigent.

Matching Necessary

Some states have already entered into "Medicaid," and all states must enter the program by Dec. 31, 1969, or lose federal health care funds now coming in for persons on welfare rolls.

The Legislature is expected to be asked in 1969 for matching funds necessary for Alabama to enter the program.

The University of Alabama was also doing some planning in 1968, on how to meet the commitments assigned to the institution by a significant report on medical education submitted several months ago to the Legislature.

Authored by the firm of Booz, Allen and Hamilton, the report said Alabama must overcome its critical shortage of physicians, and that the University of Alabama must be in charge of programs to accomplish this task.

According to the report, University of Alabama should increase the number of medical students in its own Medical College of Alabama in Birmingham; set up a two-year basic medical school in Tuscaloosa; and direct the beginning of medical education programs in Mobile and Huntsville.

To Outline Needs

The first step will be to increase the number of medical students at the Medical College of Alabama—hopefully in the fall of 1970.

The University is expected to outline its needs to accomplish these goals to the 1969 Legislature.

Finally where planning is concerned, meetings have been held in 1968 between representatives of health and industry to work out a compromise bill on air pollution control.

State Legislature is also expected to get a look at this bill during its 1969 session.

Crisis came to Alabama in 1968 as venereal disease and tuberculosis again reached epidemic proportions in many parts of the state.

Some Alabama counties were reporting numbers of new cases of active tuberculosis which is far above the national average.

Although cases of venereal diseases—namely syphilis and gonorrhea—had declined in numbers in some parts of the state from 1967 figures, the rates were still among the highest in the nation.

Flu Is Threatening

As one frustrated public official put it, "I can't figure out if Alabama is just doing a better job of finding some of its TB and VD cases than some other states, or if our rates are really that much higher."

The year came to a close with another health problem threatening Alabamians—the flu. All the chapters of that story have not yet been written.

The biggest promise for the state healthwise came on Dec. 20, with approval of a federal grant that assured the 45-block urban renewal project for expansion of the University of Alabama Medical Center in Birmingham and its closely affiliated College of General Studies.

Sen. John Sparkman placed a telephone call to Birmingham on that date to report that the federal Department of Housing and Urban Development had approved a $11.4-million grant to assure the $24-million urban renewal project.

The project will pave the way for more than $200 million in health and college buildings, thus giving a boost to educational and health opportunities, increased employment and a booming economy.

Henry VIII "Punch-Drunk"

Historians who have been blaming the erratic behavior of Henry VIII on syphilis have been completely wrong, according to Norman Rupert Barrett, senior surgeon at St. Thomas's Hospital, London. Actually, Dr. Barrett told the Royal College of Surgeons, "Good King Hal" was "punch-drunk."

To contradict the syphilis idea, the surgeon pointed out that the king's three mistresses were healthy and that there was no evidence that his four surviving children were tainted with the disease, which is hereditary.

Henry was an athlete who in his younger days jousted regularly, taking several bad falls at tournaments. After one such incident at Greenwich in 1536 he changed and was never the same again. Jousting was a form of combat on horseback.

Two months before he died, Dr. Barrett added, "he opened Parliament personally and made a speech from the throne lasting three quarters of an hour, without a note. If you read the records of that speech, you will see it was not the speech of a madman."

Calendar of Annual Meetings

Medical Association of the State of Alabama

1969, April 24-26, Carriage Inn, Huntsville

1970, April 30-May 2, Mobile

1971, April 22-24, Birmingham

1972, April 20-22, Montgomery

1973, April 18-21, Mobile

Books Of Professional Interest

SURGERY: OLD AND NEW FRONTIERS, by Robert G. Richardson, Introduction by Michael E. De Bakey, Charles Scribner's Sons, New York, 324 pages plus 22 pages of pictures—$7.95.

Originally titled *The Surgeon's Tale* when it was published in London 11 years ago, this new edition of a great book fully illustrates the continuing progress of surgery in our modern world, a progress that is accelerating.

Particularly has this progress been noted in the realms of heart surgery and the transplantation of organs, and these additions include five pages of pictures.

The "tale" begins in the hazy past of unrecorded history, emphasizing the earliest major operations—for example the ancient Peruvians' trephining of the skull, chewing coca leaves and applying the spittle to the patient's skull to reduce the pain. And it continues through the whole dramatic course of surgical history today.

Written primarily for the layman, complete with a glossary of medical terms.

LIFE ON A LITTLE-KNOWN PLANET, by Howard Ensign Evans, illustrated with drawings by Arnold Clapman, E. P. Dutton, New York, 318 pages, indexed—$7.95.

While man conquers the moon and looks beyond it to the planets and the stars of outer space, a distinguished Harvard entomologist, turns here a bright spotlight back to earth, to man's most numerous neighbors—the insects. Some of the chapter titles are more revealing than a dozen explanatory paragraphs:

The Universe as Seen from a Suburban Porch—The Intellectual and Emotional World of the Cockroach—The Cricket as Poet and Pugilist—Paean to a Volant Voluptuary: The Fly—and the concluding chapter, No. 13, "Is Nature Necessary?"

Published last October, *Life on a Little-Known Planet*, the true story of man and the insect world, is recommended as delightful, rewarding reading. —W. J. M., Jr.

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Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.

Precautions: Nonsusceptible organisms may overgrow; treat superinfection appropriately. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Side Effects: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity reactions*—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

Upon adverse reaction, stop medication and treat appropriately.

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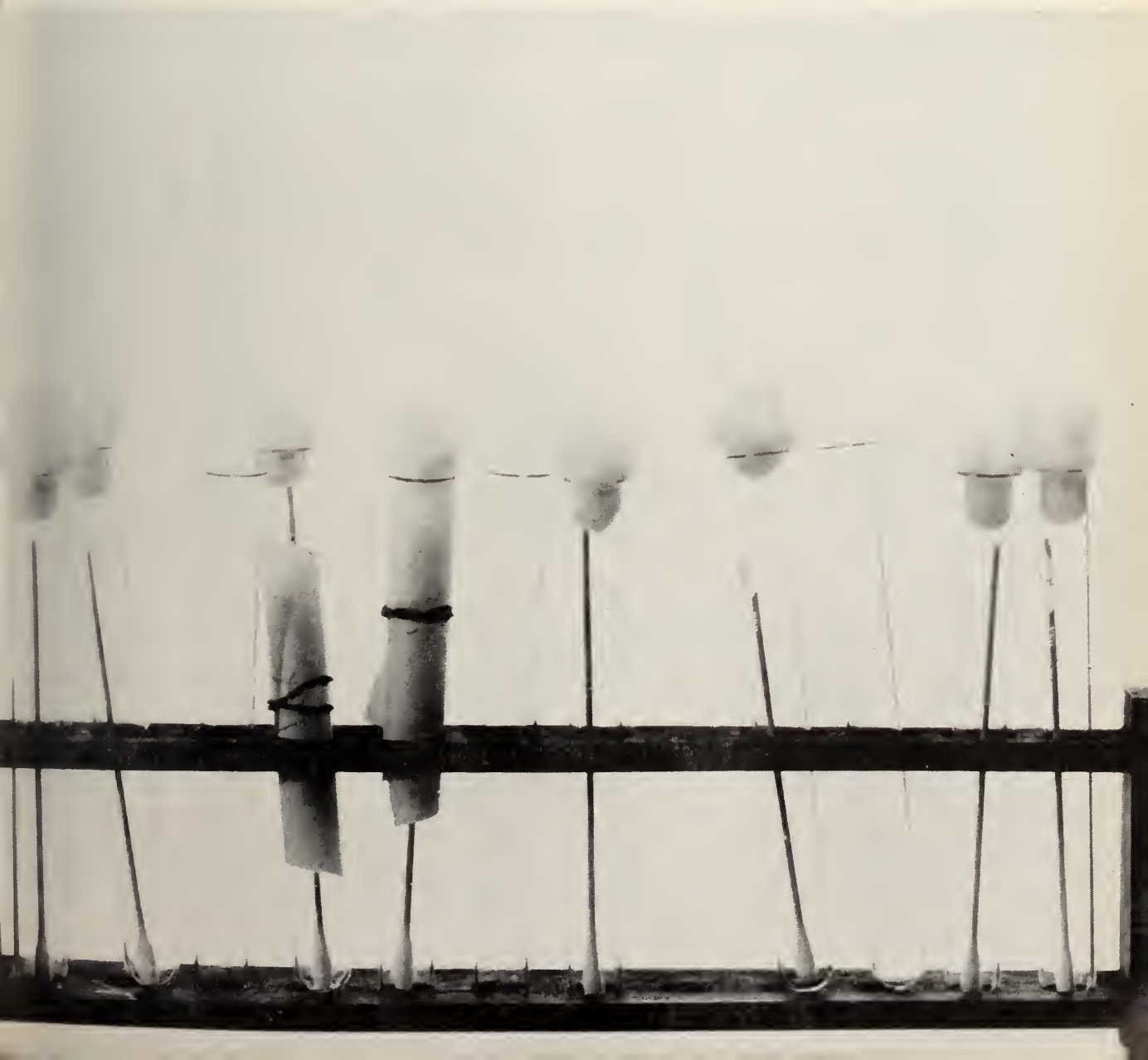
Although of course it can't replace routine sensitivity testing, your prescription for ACHROMYCIN® V, in a way, provides the ultimate test of therapy under rigorous *in vivo* conditions.

Because ACHROMYCIN® V is effective in treating so many common infections—caused by strains of tetracycline-sensitive organisms—doesn't *stat* dosage of this time-tested antibiotic make good sense?

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When Disaster Strikes . . . Are Alabama's Doctors Ready?

A volcanic eruption such as buried Pompeii in the first century of the Christian era and destroyed St. Pierre with all its 40,000 inhabitants more than 18 centuries later, is quite unlikely in Alabama.

But disaster can come . . .

As an earthquake, such as struck Shensi, China, four centuries ago, taking 830,000 lives; struck Kansu, China in 1920, killing 180,000; or has struck Tokyo more than once, most recently in 1923, snuffing out 143,000 lives . . .

As a fire, like the one that followed the 'quake in San Francisco in 1906 or, 40 years later, the holocaust that consumed the Winecoff Hotel in Atlanta . . .

As a flood or a hurricane, a tornado or a train wreck, a disease epidemic or a nuclear blast (to this very day we eye Hiroshima and Nagasaki with the thought, "it could happen here"); and in the last two years we may add to the list the recognized disaster of civil disturbances.

In any major disaster the difference between survival and death often will be the army of physicians attending it. And as these armies are divided in our country into 50 segments, it is the alphabetical No. 1 segment with which we are primarily concerned—the membership of the Medical Association of the State of Alabama, which in turn is divided into 67 parts.

Alabama's medical profession, particularly at county-society levels, has a goal of complete preparedness, whenever disaster strikes or in whatever guise it comes. The goal is still no accomplished fact, but evidences of awareness and preparation are to be found all over the state, especially in the larger counties.

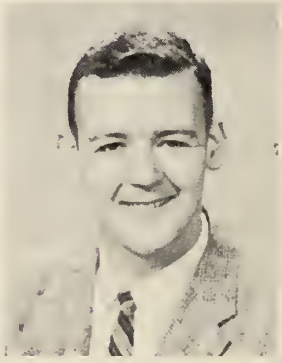
How well organized are the disaster committees at the county medical-society level? How familiar is the individual physician with his assigned responsibility? How alert is he to a summons to disaster duty, whether for practice or for real?



Dr. J. M. Barnes



Dr. B. B. Carlisle



Dr. A. R. Dimick



Dr. Shepard Jerome

Precisely as every soldier on a wartime troop transport has his assigned liferaft or lifeboat, to which he repairs when the ship is struck by a torpedo, so theoretically every doctor in the disaster program has his predetermined station in event of any catastrophe, including a nuclear attack.

Each of Alabama's four larger counties—Jefferson and Madison, Mobile and Montgomery—has its own major-disaster program involving close cooperation between the medical society, hospitals, nurses, civil defense organizations, health departments, and other related groups, including the police, ambulance service and Red Cross.

In each instance, it is a flexible program shaped to fit local situations. And it is being constantly polished, corrected and improved

(Continued on Page 738)



Blue Shield's new URC program incorporates the medical profession's freedom to set fees into a marketable program of prepaid health coverage.

BLUE CROSS-BLUE SHIELD OF ALABAMA ®

(Continued from Page 736)

by a group of dedicated doctors willing to add yet another burden to their mountain of responsibilities.

There are practice alerts at hospital levels, on a scale embracing all hospitals and the medical profession, and in at least one instance—in Mobile—one that involved the motorist on the street, the housewife in the home, and the school children.

There are situations in individual hospitals that might be a pre-glimpse of what is to come. It isn't difficult, when one hears the voice of a hospital telephone operator intoning repeatedly over the amplifiers: "Attention please. Code Blue!" (which is how doctors in one hospital are summoned to intensive care), to imagine a larger-scale and coded alert to meet a major emergency.

As they should be, the four largest counties in the state are those nearest a perfected disaster program. And these programs are sufficiently elastic to answer the disaster calls of smaller counties around them.

There is no centralized, overall command of the state's major emergency program. Every hospital belonging to the American Hospital Association is required to have two practice alerts. In all but the smaller counties of the state, there is a county medical society disaster chairman, who determines the extent of doctors' participation in these alerts. And civil defense is another major factor.

All three of these divisions were enlisted in a general practice alert in Mobile County, but such all-out effort has proved usually impractical. An emergency ambulance ordinance and an emergency medical-services program have distinguished Jefferson's progress in disaster preparedness. Communication, enlisting every vehicle with a two-way radio, and the coordination of hospitals, civil defense and the medical profession, along with the use of ready mobile units, are emphasized in the Montgomery program. And Madison County, with a tornado and two school bus accidents, has had alerts with true casualties.

Dr. Alan R. Dimick is coordinator of the Emergency Medical Services committee of the Jefferson County Medical Society, Dr. J. Mac Barnes is in the same capacity in Montgomery, Dr. Bob Carlisle in Madison, and Dr. Shepard Jerome in Mobile.

Typical comments from smaller county societies:—

"Our program is far from ideal but we plan to improve." . . . "Excellent disaster plans, with both hospitals participating." . . . "Each hospital has its own disaster program and doctors are assigned according to the hospital in which they practice." . . . "We have only four doctors, using the same hospital and seeing each other every day. But we have no disaster plan. We'll just play it by ear."

Several months ago the committee on disaster medical care, Council on National Security, American Medical Association, added "Civil Disturbances" to the list of emergencies for which disaster committees should prepare. And it issued a four-page, single-spaced suggested guideline for the medical and health community, stressing communication, assignment, available resuscitation units, and the ever-present need of adequate guards. It also pointed out that a "build-up" or "incubation" period usually permits time to prepare.

But civil disturbances apart, it is hard to realize that because nuclear devices were detonated over Hiroshima and Nagasaki nearly a quarter of a century ago, the entire world of medicine is on disaster alert.

Jefferson County's intricate, sophisticated disaster setup includes even a "hot line" linking it to the State Capitol in Montgomery, to neighboring Atlanta, and to the Strategic Air Command in Omaha, Nebraska.

Alabama doctors, each doing what he can for readiness, may be keenly proud of their progress to date in preparation and practice.



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For unproductive, allergic coughs

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Each 5 cc. contains:
Glyceryl guaiacolate ..... 100 mg.
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Codeine phosphate ..... 10.0 mg.
(warning: may be habit forming)
Alcohol, 3.5%

Non-narcotic for 6-8 hour cough control

ROBITUSSIN-DM®
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Glyceryl guaiacolate ..... 100 mg.
Dextromethorphan hydrobromide ... 15.0 mg.
Alcohol, 1.4%

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Each Cough Calmer contains:
Glyceryl guaiacolate ..... 50 mg.
Dextromethorphan hydrobromide .. 7.5 mg.

Clears sinuses and nasal stuffiness as it relieves cough

ROBITUSSIN-PE®
Each 5 cc. contains:
Glyceryl guaiacolate ..... 100 mg.
Phenylephrine hydrochloride ..... 10.0 mg.
Alcohol, 1.4%

	Robitussin	Robitussin A-C	Robitussin-DM	Cough Calmers	Robitussin-PE
Expectorant	●	●	●	●	●
Demulcent	●	●	●	●	●
Cough Suppressant		●	●	●	
Antihistamine		●			
Non-Narcotic	●		●	●	●
Long-Acting (6-8 Hours)			●	●	
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DIET AND DISEASE

E. Cheraskin, M. D., D. M. D.

W. M. Ringsdorf, Jr., D. M. D., M. S.

J. W. Clark, D. D. S.

369 pages with 52 illustrations. Index.

Published by Rodale Books, Inc.

"A lucid and heavily documented treatise detailing selective correlative and therapeutic evidence of an association between diet and diverse disorders."

—*Journal of The American Dental Association, Dec. 1968*

An exhaustive investigation by clinical and laboratory workers of the Department of Oral Medicine of the University of Alabama Medical Center, focusing attention upon the role of diet in common afflictions not usually regarded as "nutritional" in nature.

DIET AND DISEASE opens with a description of what the average American eats. It continues with a survey of the most killing and crippling diseases which plague him. Then follows a discussion of the ingredients, including diet, which make for health and disease.

Part Two attempts to tell the story of the role of diet but not in the rare classical deficiency diseases. Rather, it describes the more common and seemingly diverse ailments and problems in man's womb-to-tomb journey. Thus, it begins with infertility, a commencement of life, then concludes with ischemic heart disease and cancer in the autumnal days. The material covered in this section has been culled from many sources.

In the final section, the common dietary threads observed in the syndromes reported in Part Two are examined. Lastly, the diets characteristic of health and disease are delineated.

In the conclusion of their preface to DIET AND DISEASE, the authors write: "It is hoped that these words will catalyze more and better understanding of the relationship between diet and disease."

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Vital Statistics

NEW MEMBERS

Etowah County

Collier, James Robert, b 24, mc Ga. 49, recip Ga. 68, Etowah County Health Center, Gadsden, Ala. 35901. PH 547-6311.

Hawkins, Myron Howard, Jr., b 40, mc Ala. 67, recip NBME 68, 946 Meighan Blvd., Gadsden, Ala. 35901. GP 547-5465.

Peterson, Thomas Chalmers, b 34, mc Ala. 62, sb 63, 1039 Forrest Ave., Gadsden, Ala. 35901. D 546-4236.

Mobile County

Carroll, Marion Louis, Jr., b 32, mc Meharry 64, recip Ga. 68, 618 Stanton Road, Mobile, Ala. 36617. I 478-0443.

Harlin, Robert Shelby, b 36, mc Tulane 61, recip La. 68, 1720 Springhill Avenue, Mobile, Ala. 36604. ObG 438-4548.

Lane, Thomas Chesterfield, b 34, mc Tenn. 58, recip Miss. 64, 1733 Springhill Ave., Mobile, Ala. 36604, Pr 433-2265.

Lester, Frank Martin, b 38, mc Ala. 63, sb 64, 1217 Government St., Mobile, Ala. 36604. I 433-6525.

Speir, Betty Ruth, b 34, mc Ala. 63, sb 64, 2062-B Dauphin St., Mobile, Ala. 36606. ObG 471-2519.

Montgomery County

Alford, James Huston, Jr., b 37, mc Ala. 63, sb 64, 750 Washington Ave., Montgomery, Ala. 36104. Ob 272-3365.

Alphin, Thomas Henry, b 14, mc Va. 47, recip Va. 68, State Office Building, Montgomery, Ala. 36104. PH 265-2341.

Collins, Dierdre Sherwood, b 37, mc Univ. Chicago, 65, recip Wis. 67, 2105 E. South Blvd., Montgomery, Ala. 36111. Anes 263-9492.

Garrick, Jean, b 27, mc Georgetown Univ. 65, recip Md. 68, 834 Adams Ave., Montgomery, Ala. 36104. Path 285-4310.

Marshall, Wallace Sydney, b 04, mc Northwestern 32, recip Wis. 34, 1602 Pine Needle Rd., Montgomery, Ala. 36106. P 272-1408.

Sheehan, Lucius Clyde, Jr., b 24, mc Ga. 57, recip Ga. 59, 2900 McGehee Rd., Montgomery, Ala. 36111. Or 263-4419.

Tankersley, Felix Marcus, b 35, mc Ala. 64, sb 65, 2119 East South Blvd., Montgomery, Ala. 36111. Ob 288-0213.

Walker County

Harp, Richard Davis, b 38, mc Ala. 64, sb 65, Crescent Circle, Jasper, Ala. 35501. R 384-6553.

Olsen, Frank Bernard, b 12, mc Col. Univ. 36, recip Col. 68, 600 East 19th, Jasper, Ala. 35501. GP 387-1130.

Washam, James Marvin, Jr., b 31, mc Ala. 59, sb 59, P. O. Box 1389, Jasper, Ala. 35501. GP 387-2161.

NON-MEMBERS

Lauderdale County

Nofzinger, John David, b 26, mc Ohio State Univ. 58, recip Ohio 68, 220 West Tennessee Street, Florence, Ala. 35630.

DEATHS

Dallas County

Pilkington, John Shelton, P. O. Box 579, Selma, Ala. 35701—deceased December 11, 1968.

Etowah County

Faucett, DeWitt, 630 Turrentine Ave., Gadsden, Ala. 35901—deceased October 31, 1968.

Jefferson County

McCay, Timothy Cleveland, Box 106, Pinson, Ala. 35126—deceased.

Marengo County

Greene, Gilbert Bamford, Demopolis, Ala. 36732—deceased December 3, 1968.

TRANSFERS

Coffee County

Foy, Robert Edward, Jr., 400 North Edwards, Enterprise, Ala. 36330. (Transfer from member of Jefferson County Medical Society to Coffee County Medical Society.)

Montgomery County

Montgomery, Hubert Theron, Jr., 2119 East South Blvd., Montgomery, Ala. 36111. (Transfer from member of Jefferson County Medical Society to Montgomery County Medical Society.)

CHANGE OF ADDRESS

Calhoun County

Elliott, Robert L., Jr., present Anniston, Ala. 36201, to 411 East 9th Street, Anniston, Ala. 36201.

Chambers County

Lowe, Richard T., present Langdale, Ala. 36864, to 605 South 4th Street, Lanett, Ala. 36863.

Jefferson County

Bancroft, Josiah D., present Birmingham, Ala. 35233, to 1909 Laurel Rd., Birmingham, Ala. 35216.

Crowe, Aubrey D., present Birmingham, Ala. 35233, to 1000 South 14th Street, Birmingham, Ala. 35205.

Ippolito, Jerome G., present Birmingham, Ala. 35205, to 3361 Highland Station, Birmingham, Ala. 35205.

Norman, Patricia H., present Birmingham, Ala. 35223, to 2912 Virginia Rd., Birmingham, Ala. 35233.

Lauderdale County

Bennett, Ann, present Florence, Ala. 35630, to 106 South Locust Street, Florence, Ala. 35630.

Bennett, Thomas L., Jr., present Florence, Ala. 35630, to 106 South Locust Street, Florence, Ala. 35630.

Burford, Alexander M., Jr., present Florence, Ala. 35630, to P. O. Box 1079, Florence, Ala. 35630.

Dunn, Milton C., present Florence, Ala. 35630, to 220 West Tennessee Street, Florence, Ala. 35630.

Madison County

Striplin, William H., Jr., present Huntsville, Ala. 35801, to 800 Gallatin Street, Huntsville, Ala. 35801.

Mobile County

Brown, Nelson L., present Mobile, Ala. 36602, to 1406 Dauphin Street, Mobile, Ala. 36604.

McGrew, Richard M., Jr., present Bayou LaBatre, Ala. 36509, to P. O. Drawer, Flomaton, Ala. 36441.

Tunstall, Peyton R., Jr., present Mobile, Ala. 36602, to 1406 Dauphin Street, Mobile, Ala. 36604.

Montgomery County

Pugh, Walter H., present Montgomery, Ala. 36104, to 2900 McGehee Road, Montgomery, Ala. 36111.

One Way To Pay Off Medical-College Loan

Young doctors who have finished the University of Alabama Medical College on loans up to $8,000, won't have to repay a penny of it in cash.

Their alternative is service in an underprivileged section of the state or an area that needs more doctors.

Forty-nine of Alabama's 67 counties are marked "rural low income areas" in a list just released through Dr. Ira L. Myers of the Department of Public Health, by the Department of Health, Education and Welfare.

Under Alabama law, the loan may be repaid by practicing "for a 4-year period in a community of less than 5,000 population which has been deemed to be critically in need of additional medical practitioners" or "for a 4-year period in a community of more than 5,000 population and less than 15,000 population which has been deemed to be critically in need of additional medical practitioners."

The borrower may repay half his loan by practicing for a five-year period in a community of more than 15,000 but less than 100,000 population, and the remaining half is to be repaid plus 6 per cent simple interest annually in five annual payments, beginning at the end of the first year of practice.

He may repay the loan by practicing "for four years in a position in Alabama in public health or as a physician in any state institution approved by the board of medical scholarship awards."

The just-released list shows a shortage of 292 doctors over the state, and of 293 dentists, plus 92 optometrists.

The heaviest shortages of doctors are reported in Russell (19), Dale (17), DeKalb and Calhoun (15 each), Lee (13), Madison, Shelby and Talladega (12 each), Chilton, Cullman, and Limestone (11 each), Blount and St. Clair (10), Jackson and Pickens (9), Hale and Lawrence, Lowndes and Pike (8), Autauga, Coosa, Elmore, and Monroe (7 each), and Baldwin, Chambers, Cherokee, Clarke, Cleburne, and Wilcox (6).

Mobile is the foremost county in need of dentists, listing 15, with Russell next with 14, Chambers 11, and Etowah and Talladega 10 each.

In the following list, "P" is for Physicians, "D" for Dentists, and the asterisks denote counties classified as low-income areas:

County	P	D
Autauga*	7	4
Baldwin*	6	5
Barbour*	3	5
Bibb*	2	4
Blount*	10	6
Bullock*	1	3
Butler*	8	6

(Continued on Page 747)

To fight TB- find it first!

Make tuberculin testing routine with every physical examination.



TUBERCULIN TINE TEST (Rosenthal)

Side effects are possible but rare: vesiculation, ulceration, or necrosis at test site. Contraindications: none, but use with caution in active tuberculosis. Available in 5's and 25's.

Lederle

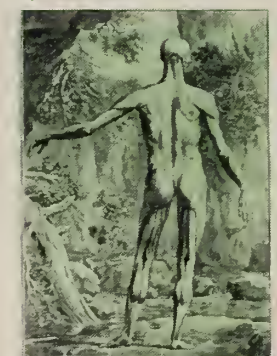
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When familiar situations are a major challenge to your patient with low back pain



Norflex® meets the challenge

(orphenadrine citrate, 100 mg.)



Norflex relaxes the muscles in spasm, restoring mobility and hastening recovery.

Take the agony out of low back pain... prescribe Norflex, 1 tablet b. i. d.



To relieve skeletal muscle spasm... Norflex® tablets.
(orphenadrine citrate)

Indications:
Acute spasm of voluntary muscles, regardless of location; especially post-traumatic, discogenic, and tension spasms.

Contraindications:
Due to its anticholinergic action, NORFLEX should not be used in patients with glaucoma, pyloric or duodenal obstruction, stenosing peptic ulcer, prostatic hypertrophy or obstruction at the bladder neck, cardiospasm (megaesophagus) and myasthenia gravis. Use with caution in patients with tachycardia. Do not use propoxyphene (Darvon®) concurrently.

Adverse Reactions:
Due mainly to anticholinergic action and usually at high dosage. They may include dryness of the mouth, tachycardia, palpitation, urinary hesitancy or retention, blurred vision, dilatation of the pupil, increased ocular tension, weakness, nausea, vomiting, headache, dizziness, constipation and drowsiness. Infrequently, mental confusion in the elderly, urticaria or other dermatoses. Adverse reactions are usually eliminated by reduction in dosage. Two cases of aplastic anemia, with no established causal relationship, have been reported.

Dosage and Administration:
Two tablets per day for adults, regardless of weight or sex; one in the morning and one in the evening. Each tablet contains 100 mg. orphenadrine citrate.

For full information, see Package Insert or P.D.R.

Norflex®
(orphenadrine citrate)

Riker Laboratories
Div. Rexall Drug & Chemical Co.
Northridge, California 91324

ONE WAY TO PAY OFF MEDICAL-COLLEGE LOAN

(Continued from Page 745)

County	P	D
Calhoun	15	9
Chambers*	6	11
Cherokee*	6	4
Chilton*	11	5
Choctaw*	3	4
Clarke*	6	3
Clay*	4	3
Cleburne*	6	2
Coffee	4	2
Colbert	3	5
Conecuh*	5	4
Coosa*	7	3
Covington	1	3
Crenshaw*	4	1
Cullman*	11	4
Dale*	17	9
Dallas		5
DeKalb*	15	8
Elmore*	7	3
Escambia*	2	2
Etowah		10
Fayette*	4	1
Franklin*		3
Geneva*	5	4
Greene*	5	4
Hale*	8	5
Henry*	5	4
Jackson*	9	8
Jefferson		
Lamar*	5	3
Lauderdale		2
Lawrence*	8	6
Lee	13	4
Limestone*	11	4
Lowndes*	8	4
Macon*	5	2
Madison	12	1
Marengo*	5	3
Marion*	2	4
Marshall*	3	1
Mobile		15
Monroe*	7	2
Montgomery		

(Continued on Page 748)

(Continued from Page 747)

County	P	D
Perry*	5	2
Pickens*	9	4
Pike*	8	3
Randolph*	4	4
Russell	19	14
St. Clair*	10	4
Shelby*	12	8
Sumter*	7	4
Talladega	12	10
Tallapoosa	1	5
Tuscaloosa		3
Walker*	4	9
Washington*	7	4
Wilcox*	6	6
Winston*	3	

ANNOUNCEMENT

Title: A Course in Current Problems in Electroencephalography: Advances toward their solution

Date: March 13-15, 1969

Place: Houston, Texas

Sponsors: The American Electroencephalographic Society and Baylor University College of Medicine

For further information contact:

Dr. Peter Kellaway, Baylor University College of Medicine, Texas Medical Center, Houston, Texas 77025

Bridge the Generation Gap

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Here is a good means of expressing your well wishes in a practical and comradely way to the young people who are the future of your profession.

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"The inconvenience of a cold"

For a cold, NTz® Nasal Spray provides rapid relief of nasal symptoms. Relief starts with the first spray which opens the inferior part of the common meatus. A second spray, a few minutes later, will shrink the turbinates to help provide sinus drainage and ventilation. Dosage may be repeated every three or four hours as needed, for temporary relief of symptoms. NTz is well tolerated but overdosage should be avoided.

As a sinusitis deterrent, NTz Nasal Spray can be used to keep the nasal passages open during a cold to help prevent development of acute sinusitis—or to help prevent the acute condition from becoming chronic.

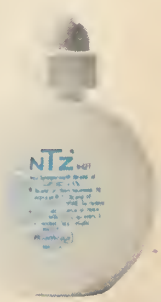
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Thenfadil® (brand of thenyldiamine) HCl 0.1 per cent, topical antihistamine for reduction of rhinorrhea, sneezing or itching. It combats the allergic reactions that may occur in colds or sinusitis.

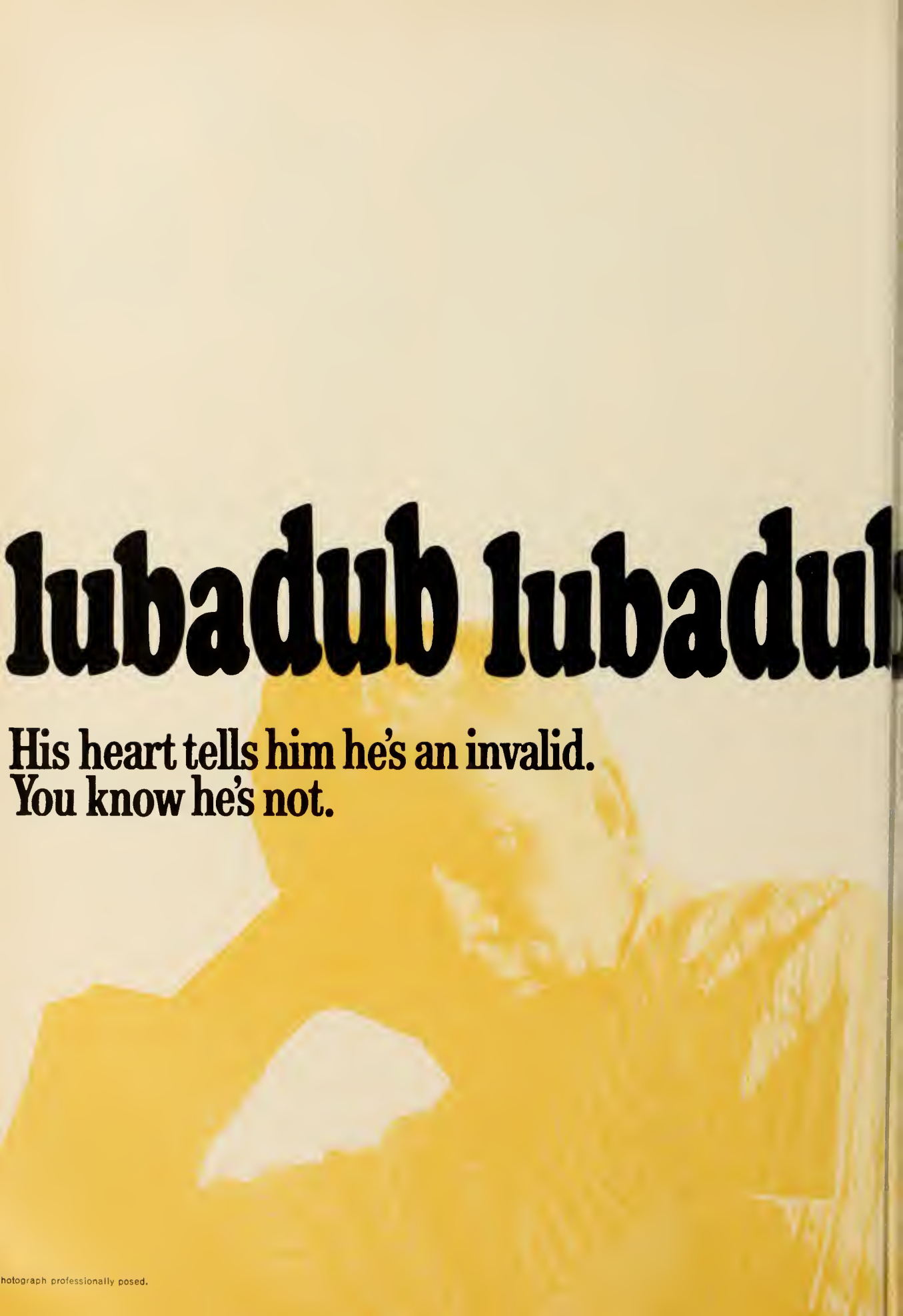
Zephiran® (brand of benzalkonium, as chloride, refined) 1:5000, antiseptic preservative and wetting agent to promote penetration and spread of the formula.



Winthrop Laboratories, New York, N.Y. 10016 Winthrop

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His heart tells him he's an invalid.
You know he's not.



hotograph professionally posed.

Contraindications: History of sensitivity to meprobamate.

Important Precautions: Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use has been reported to result in dependence or habituation in susceptible persons, as alcoholics, ex-addicts, and other severe psychoneurotics. After prolonged excessive dosage, reduce dosage gradually to avoid possibly severe withdrawal reactions. Abrupt discontinuance of excessive doses has sometimes resulted in epileptiform seizures.

Warn patients of possible reduced alcohol tolerance, with resultant slowing of reaction time and impairment of judgment and coordination.

Reduce dose if drowsiness, ataxia or visual disturbance occurs; if persistent, patients should not operate vehicles or dangerous machinery.

Side Effects include drowsiness, usually transient; if persistent and associated with ataxia, usually responds to dose reduction; occasionally concomitant CNS stimulants (amphetamine, mephentermine sulfate) are desirable. Allergic or idiosyncratic reactions are rare, but such reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Previous history of allergy may or may not be related to incidence of reactions. Mild reactions are characterized by itchy urticarial or erythematous maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically as with epinephrine, antihistamine and possibly hydrocortisone. Aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia have occurred rarely, almost always in presence of known toxic agents. A few cases of leukopenia, usually transient, have been reported on continuous administration.

Meprobamate may sometimes precipitate grand mal attacks in patients susceptible to both grand and petit mal. Extremely large doses can produce rhythmic fast activity in the cortical pattern. Impairment of accommodation and visual acuity has been reported rarely. After excessive dosage for weeks or months, withdraw gradually (1 or 2 weeks) to avoid recurrence of pretreatment symptoms (insomnia, severe anxiety, anorexia). Abrupt discontinuance of excessive doses has sometimes resulted in vomiting, ataxia, tremors, muscle twitching and epileptiform seizures. Prescribe very cautiously and in small amounts for patients with suicidal tendencies. Suicidal attempts have resulted in coma, shock, vasomotor and respiratory collapse and anuria. Excessive doses have resulted in prompt sleep; reduction of blood pressure, pulse and respiratory rates to basal levels; and occasionally hyperventilation. Treat with immediate gastric lavage and appropriate symptomatic therapy. (CNS stimulants and pressor amines as indicated.) Doses above 2400 mg./day are not recommended.

Composition: Tablets, 200 mg. and 400 mg. meprobamate. Coated Tablets, WYSEALS® EQUANIL (meprobamate) 400 mg. (All tablets also available in REDIPAK® [strip pack], Wyeth.) Continuous-Release Capsules, EQUANIL L-A (meprobamate) 400 mg.

Wyeth Laboratories Philadelphia, Pa.

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Anxiety is expected in the cardiovascular patient. A little may even be desirable.

But when anxiety is exaggerated . . . when it interferes with sleep . . . when it aggravates cardiovascular symptoms, your help may be needed.

Naturally, you'll want to reassure the patient.

And perhaps prescribe Equanil (meprobamate) as adjunctive therapy. It helps relieve anxiety and tension specifically, yet gently.

Almost 15 years' use has shown that Equanil is usually well tolerated as well as effective. Side effects are generally limited to transient drowsiness; serious, therapy-interrupting side effects are rare.

Equanil®
(meprobamate) Wyeth®



The two-stage power of the pink pill for U.R.I. symptoms is nothing to be sneezed at.

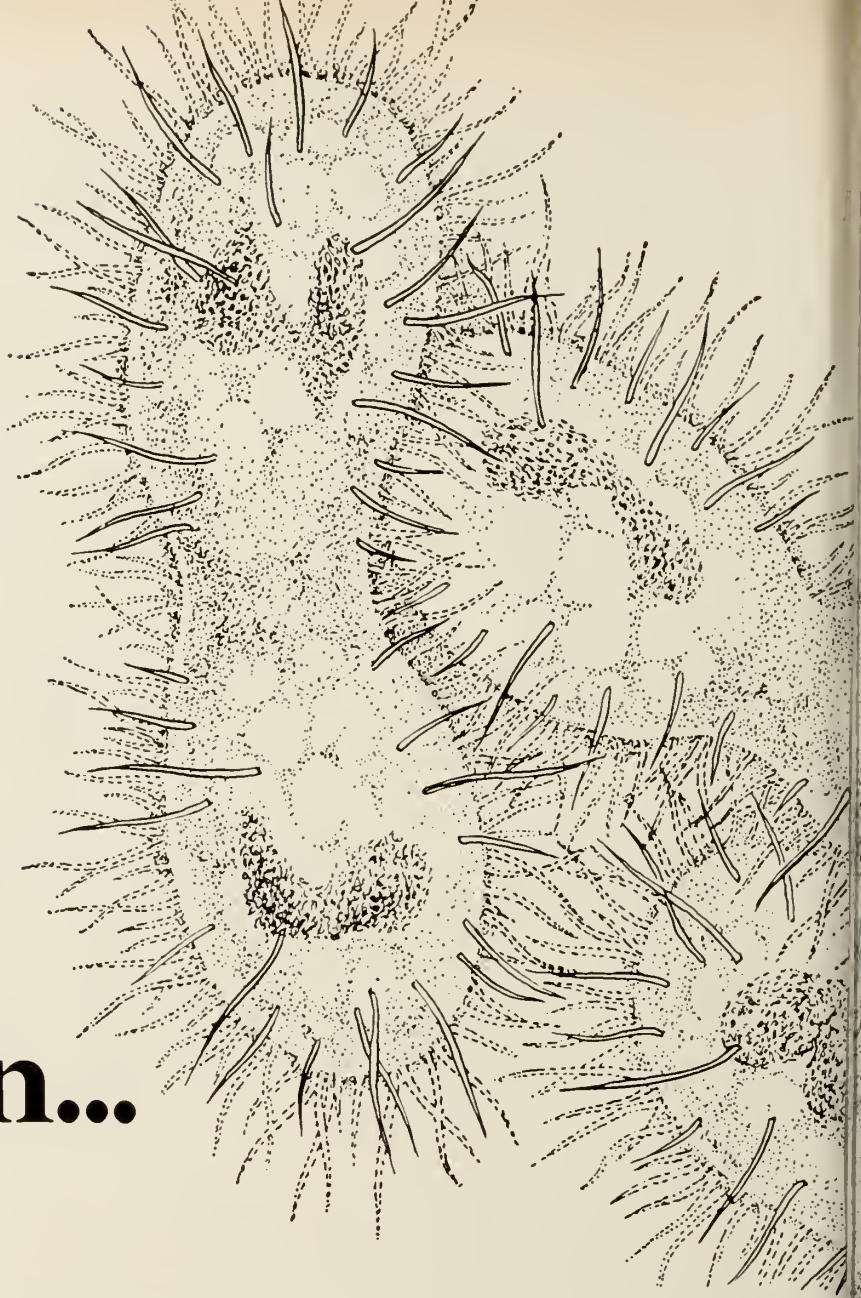
The immediate and continuous-release actions built into each Novahistine Singlet can give most of your patients prompt and long-lasting relief from symptoms of upper respiratory infection, including fever, aches and pains. Not only does Novahistine Singlet provide a vasoconstrictor-antihistamine formulation to reduce congestion and help restore normal ciliary activity; it also contains an antipyretic-analgesic compound to relieve the fever, aches and pains that so frequently accompany upper respiratory infections. A total daily dosage of 3 or 4 tablets will normally provide the continuous relief your patient expects. Use with caution in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

Pitman-Moore Division of
The Dow Chemical Company,
Indianapolis, Indiana.

Novahistine®
Singlet decongestant-analgesic

(Each tablet contains: phenylephrine hydrochloride, 40 mg.; chlorpheniramine maleate, 8 mg.; acetaminophen, 500 mg.)

DOW



A high index of suspicion... E. coli

How high is the "index of suspicion" for *E. coli* in urinary tract infections?

Recently it has been estimated that about 86 per cent of positive cultures in first attacks of urinary tract infection are *E. coli*.[1] It has also been noted that "The coliform group, especially *E. coli*, accounts for approximately 90 per cent of initial infections...."[2]

Consider wide-spectrum Gantanol® (sulfamethoxazole) for its high "index of confidence"—its proven effectiveness against *E. coli* and other sensitive gram-negative and gram-positive organisms. Therapeutic levels of Gantanol in blood and urine are achieved within 2 hours after a 2-Gm starting dose, with ready diffusion into interstitial fluids. Responsive infections generally clear within 5 to 7 days, with relief of symptoms usually seen within 24-48 hours.

Gantanol also earns its high "index of confidence" because Gantanol therapy is relatively free from complications, including the problem of bacterial resistance or superinfection.

Convenient, economical dosage schedule: *b.i.d.*

References: 1. Vernier, R. L., in Patient Care Feature: *Patient Care, 1*:20 (Feb.) 1967. **2.** Beeson, P. B.: "The Infectious Diseases," in Beeson, P. B., and McDermott, W. (eds.): *Cecil-Loeb Textbook of Medicine*, ed. 12, Philadelphia, W. B. Saunders Company, 1967, p. 230.

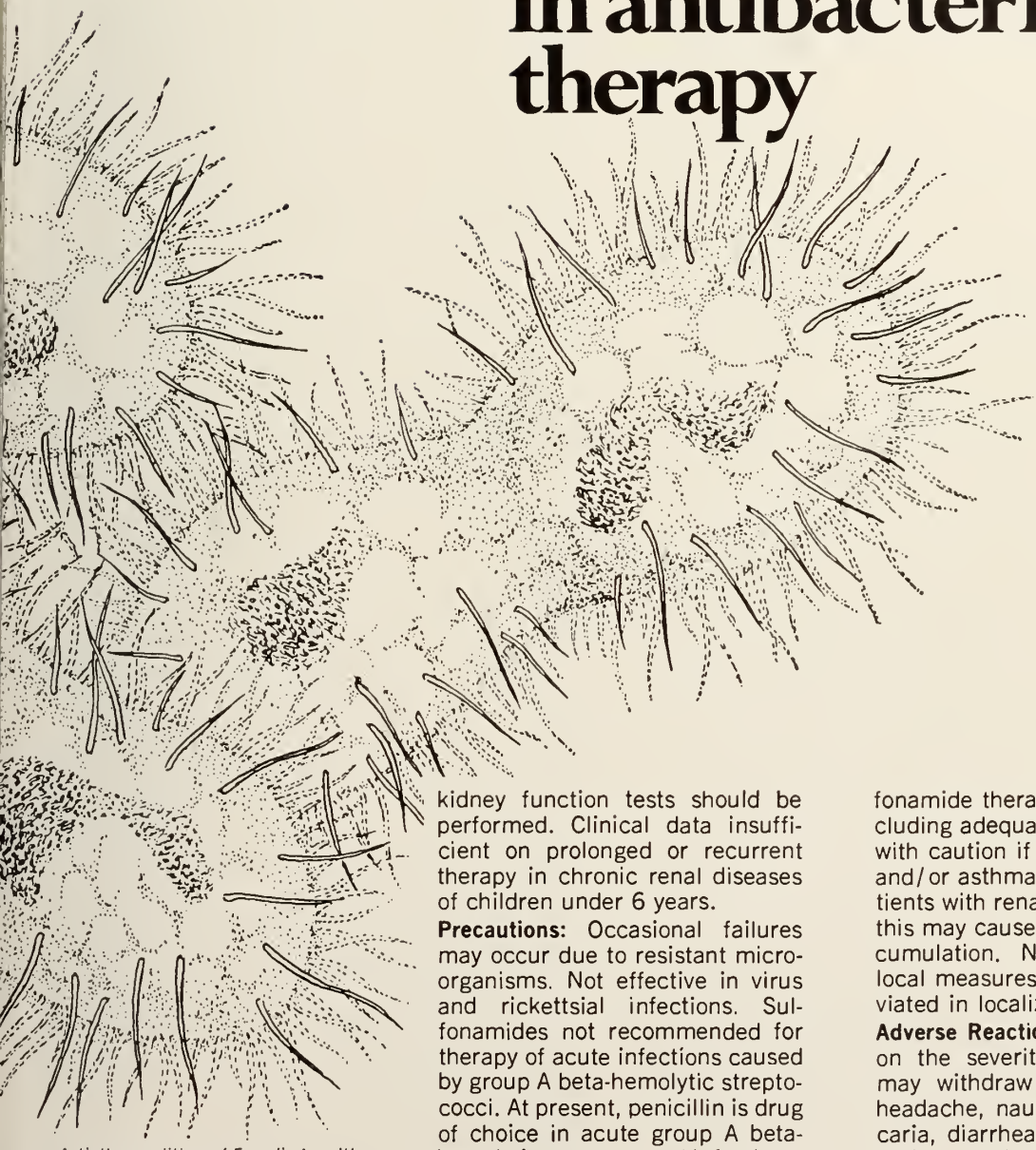
Before prescribing, please consult complete product information, a summary of which follows:

Indications: Acute and chronic urinary tract, respiratory and soft tissue infections due to susceptible microorganisms; prophylactically following diagnostic instrumental procedures on genitourinary tract.

Contraindicated in sulfonamide-sensitive patients, pregnant females at term, premature infants, or newborn infants during first 3 months of life.

Warnings: Use only after critical appraisal in patients with liver or renal damage, urinary obstruction or blood dyscrasias. Deaths reported from hypersensitivity reactions, Stevens-Johnson syndrome, agranulocytosis, aplastic anemia and other blood dyscrasias. In closely intermittent or prolonged therapy, blood counts and liver and

For a high index of confidence... Gantanol® (sulfamethoxazole) in antibacterial therapy



Artist's rendition of E. coli. As with most strains of E. coli, these have flagella and are motile.

kidney function tests should be performed. Clinical data insufficient on prolonged or recurrent therapy in chronic renal diseases of children under 6 years.

Precautions: Occasional failures may occur due to resistant microorganisms. Not effective in virus and rickettsial infections. Sulfonamides not recommended for therapy of acute infections caused by group A beta-hemolytic streptococci. At present, penicillin is drug of choice in acute group A beta-hemolytic streptococcal infections; although Gantanol has produced favorable bacteriologic conversion rates in this infection, data insufficient on long-term follow-up studies as to its effect on sequelae of rheumatic fever or acute glomerulonephritis. If other treatment cannot be used and Gantanol is employed in such infections, *important that therapy be continued in usual recommended dosage for at least 10 days.* Observe usual sulfonamide therapy precautions, including adequate fluid intake. Use with caution if history of allergies and/or asthma. Follow closely patients with renal impairment since this may cause excessive drug accumulation. Need for indicated local measures or surgery not obviated in localized infections.

Adverse Reactions: Depending upon the severity of the reaction, may withdraw drug in event of headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, Stevens-Johnson syndrome, skin rash, injection of the conjunctiva and sclera, petechiae, purpura, hematuria and crystalluria.

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PHYSICIAN PLACEMENT SERVICE IN ALABAMA

The Physician Placement Service of the Medical Association of the State of Alabama is designed to assist both physicians and communities. MASA members having knowledge of practice opportunities or wishing to relocate their own practices are urged to communicate with the Placement Service. For further information: write Mr. Emmett Wyatt, Executive Assistant, Medical Association of the State of Alabama, 19 South Jackson Street, Montgomery, Alabama 36104, or Telephone 263-6441.

Locations Wanted

General Practice—

Age 44, Medical College of Alabama, 1967, seeking associate practice in town of 12,000 plus population in central or south Alabama. LW-1

Age 56, Georgetown University 1938; seeking solo, group or associate practice, with general surgery. LW-2

Age 52; University of Chicago 1950; seeking group, industrial, institutional or student health position. LW-3

Age 31, Western Reserve, 1964; seeking group, associate or institutional practice. LW-4

Age 38; University of Oklahoma, 1955; seeking associate, institutional or industrial practice; in town of 10,000 plus population; interest in surgery. LW-5

Age 28; Medical College of Alabama 1966; seeking practice in town of less than 14,000 population to fulfill scholarship requirements. Available 1968. LW-6

Age 28; University of Tennessee, 1965; available November 1968. LW-7

Age 27, Medical College of South Carolina, 1966; seeking location in Gadsden area or in southern part of state in town of 5-7,000 population; available July 1, 1971. LW-7/1

Age 38; Medical College of Alabama, 1957; seeking location in south Alabama. LW-7/2

Internal Medicine—

Age 36, Medical College of Alabama, 1963; seeking solo, group, or associate practice. LW-8

Age 34; University of Mississippi 1960; Board eligible; seeking location in southern section of Alabama in city of 15,000 plus population. LW-9

University of Mississippi 1963; seeking group practice in city of 20,000-40,000 population. LW-10

Age 34; Hahnemann Medical College 1959; Board eligible, National Board; seeking solo, group, or associate practice. Available immediately. LW-11

Age 35; University of Tennessee 1958; Board certified; seeking group, industrial or institutional practice. LW-12

Age 37, Duke University, 1956; Board certified, seeking group, associate, or institutional practice. LW-13

Neurology—

Age 32, Medical College of Georgia, 1964, seeking assistant or associate, or institutional practice. LW-14

Age 31; Harvard 1962; Board eligible; National Board; seeking solo, group or associate practice. Available July 1969. LW-15

Age 30; Medical College of Alabama 1962; Board eligible; National Board; seeking solo, group, associate or institutional practice. Available January 1969. LW-16

Age 31; University of Virginia 1962; Board eligible; seeking associate or group practice. Available August 1969. LW-17

Age 29, Indiana Univ., 1964; Board eligible; seeking assistant or associate practice in city of over 100,000 population; available July 1, 1969. LW-17/1

Obstetrics-Gynecology—

Age 35, Vanderbilt University, 1950. Board eligible. LW-18

Age 49, University of Nebraska, 1943; Board certified, seeking group or institutional practice. LW-19

Age 34, Medical College of Virginia, 1961, Board eligible, seeking group or associate practice. LW-20

Age 33; University of Illinois, 1964; seeking associate practice. LW-21

Ophthalmology—

Age 33; St. Louis University, 1962; seeking solo, or associate practice; available July 1, 1969. LW-21/1

Radiology—

Age 39; Louisiana State University 1954; seeking solo or associate practice. Available July 1969. LW-22

Age 31; S. U. N. Y. College of Medicine, 1961; Board eligible; seeking solo, group, or associate practice. LW-23

Age 41; Cornell Univ. Medical School, 1953; Board certified; seeking group, or associate practice. Available immediately. LW-24

Age 51; Univ. of Texas Med. Branch, 1942; Board certified; seeking solo, group, or associate practice. LW-25

Surgery—

Age 30; Duke University School of Medicine, 1964; seeking location in larger cities. LW-26

Age 33; University of Missouri, 1961; seeking group or associate practice. Available January 1969. LW-27

Age 38; Emory University, 1956; Board eligible, seeking group, associate, or institutional practice. LW-28

Locations Wanted

(Continued)

Age 37; Faculty of Medicine, Manitoba, 1957; Board certified; seeking associate or institutional practice. LW-29

Age 34; University of Santo Tomas, 1961; Board eligible, seeking group or associate practice. LW-30

Age 35; University of Santo Tomas, 1956; Board eligible, seeking solo, group or industrial or associate or institutional practice. LW-31

Age 31; Medical College of Alabama, 1962; Board eligible; passed National Board; seeking assistant, associate, institutional or group practice in city of over 50,000. Available July 1969. LW-31/1

Urology—

Age 30; Louisiana State University, 1963; Board eligible, seeking associate, or group practice. LW-32

Physicians Wanted

General Practitioners—

Opportunity in town of 4,000 population in trade area of 50,000 population, located within 100 miles of two metropolitan areas in south Alabama. Industrial and farming area. 44-bed hospital. Office space and equipment available in new building with another physician. Several churches, schools, and service clubs. PW-1

For community of 1,500 population located in south Alabama near city of 12,000 population. Hospitals located within 25 miles. Office space and equipment available. Farming, cattle and textile industries in the area. Several churches and school. Civic clubs and golf courses. PW-1-1

Opportunity for group practice in town of 10,000 population in north Alabama. PW-2

Physician wanted to join 39 year old Medical College of Alabama graduate in a well established general practice in West Central Alabama town. Salary initially followed soon by full partnership. PW-3

Opportunity in community of 5,000 population in trade area of 30,000 population located in northeast Alabama where at present time there are only two active full time general practitioners. Modern offices or clinic facilities available. 48-bed accredited hospital and 52-bed skilled nursing home adjoining the hospital. Cities of approximately 75,000 population located within 25 miles distance. Agricultural and expanding industrial area. Numerous churches and schools. Country club and golf course being developed and water sports and outdoor activities offer recreational advantages. PW-4

For town of 2,000 population in trade area of 5,000 located in South Alabama, within 24 miles of large city of 37,000 population. Nearest hospital (50 beds) is 12 miles away. One physician presently in practice in town. Office space available. Military base, farming, and small industries afford resources. Numerous civic clubs, two schools, and five churches. PW-5

For town of 4,500 population in trade area of 10,000 to 15,000 with annual payroll of 4½ million dollars, located in north central Alabama. Within 75 and 85 miles respectively of two metropolitan areas with combined population of 2 million. Hospital privileges available in modern 30-bed hospital. A modern 40-bed extended care facility adjoins hospital. Excellent churches, schools and shopping areas. In the center of the best hunting, fishing and recreational area in the state. PW-6

Physician wanted to join well established partnership in Northwest Alabama city of 15,000 population. Two accredited hospitals, junior college, schools, churches, recreational activities. No obstetrics or surgery. New office building. PW-7

For city of approximately 15,000 population in north Alabama, with trade area of approximately 45,000 population. Hospital with over 100 beds, and expansion planned for next year. Nursing homes in the area. Industrial growth and agricultural region. Several churches and schools. Golf course, civic and fraternal organizations. PW-8

For partnership practice in clinic in town of 2,000 population in area of 10,000 population located in north-central Alabama. 40-bed hospital. PW-9

For assistant or associate in clinic located in town of 10,000 population located in northeast Alabama. 65-bed Hill-Burton hospital. PW-10

For associate practice in city of 6,000 population in area of over 10,000 population located in East-central Alabama. PW-11

For solo practice in county clinic located in East-central Alabama. Office, equipment and housing available. 70-bed Hill-Burton Hospital and 22-bed nursing home. PW-12

For town in southwest Alabama, approximately 1,000 population in trade area of approximately 5,000 population, within 60 miles of large city of 35,000. Nearest hospital is located 18 miles away. Arrangements available for office space. Small industries and agriculture. Civic clubs and golf course nearby. Churches and school. PW-13

For town of approximately 1,000 population in population center of 10,000 located in Southwest Alabama within 90 miles of the Gulf coast. City owned clinic is offered rent free and fully equipped. Hospitals are located in two nearby towns within 25 miles. This is principally an agricultural region, but there are military installations nearby. Numerous civic clubs, community concert series, and a country club offer recreational activities. PW-14

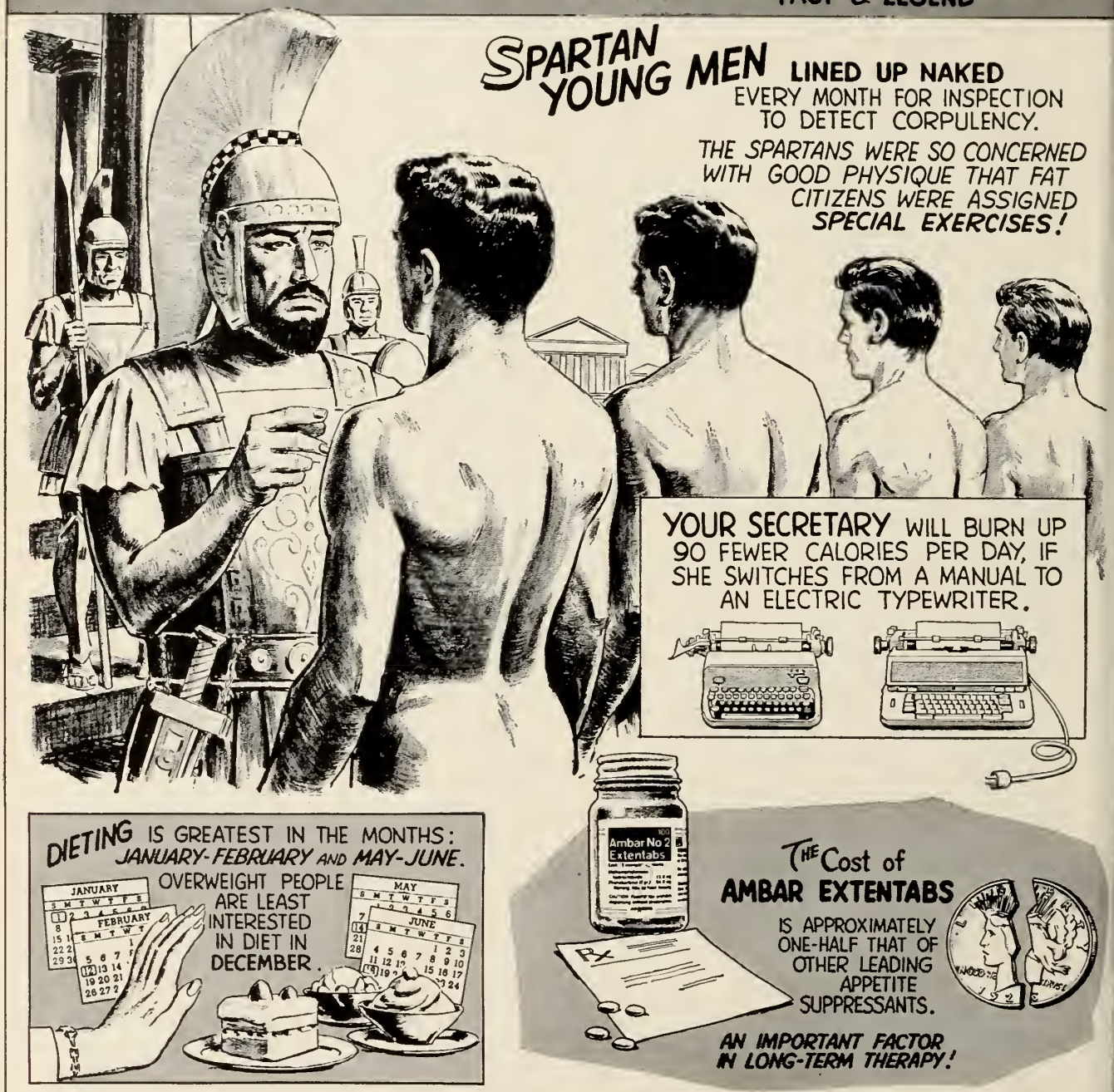
For town of 1,000 plus population in west-central Alabama in trade area of 20,000. Clinic available. Nearest city of approximately 70,000 population is located a distance of 17 miles. Farming, cattle, timber, and manufacturing plants are principal resources of the area. Churches, schools, and recreational advantages. PW-15

(Continued on Page 759)

The AMBAR SCRAPBOOK of

Obesity Oddities

FACT & LEGEND



CONTROL FOOD AND MOOD ALL DAY LONG WITH A SINGLE MORNING DOS

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methamphetamine HCl 15 mg., phenobarbital 64.8 mg. (1 gr.)
(Warning: may be habit forming).

One Ambar Extentab before breakfast can help control most patients' appetite for up to 12 hours. Methamphetamine, the appetite suppressant, gently elevates mood and helps overcome dieting frustrations. Phenobarbital, the sedative in Ambar, controls irritability and anxiety...helps maintain a state of mental calm and equanimity. Both work together to ease the tensions that erode the willpower during periods of dieting.

Also available: Ambar #1 Extentabs®—methamphetamine hydrochloride 10 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

BRIEF SUMMARY/**Indications:** Amb suppresses appetite and helps offset em tional reactions to dieting. **Contraindic tions:** Hypersensitivity to barbiturates sympathomimetics; patients with advanc renal or hepatic disease. **Precautions:** Administer with ca tion in the presence of cardiovascular disease or hypertensio **Side Effects:** Nervousness or excitement occasionally note but usually infrequent at recommended dosages. Slight drow iness has been reported rarely. See package insert for furth details.

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Physicians Wanted

(Continued From Page 757)

Opportunity for general practitioner to join a five-man group, practicing as a partnership. Each man in the group is either specialized or semi-specialized. The practice is physically located within a 70-bed hospital. Willing to pay qualified person $36,000 for the first year, with possible partnership status in one year. Would consider a physician for locum tenens for three to six months at $2,000 per month. PW-16

For town of 3,600 population in trade area of 5,000-7,000 within 100 miles of two large cities and the Gulf Coast. 50-bed hospital located in the town. Office space available. Agricultural and expanding industrial area. Several churches and two schools. Recreational activities in the town as well as nearby—golf course, hunting and fishing. PW-17

Unusual opportunity for two general practitioners with military obligations satisfied at a modern fifty bed facility located 15 minutes drive from largest metropolitan center in north-central Alabama. Construction of a new two-story office building is scheduled to begin soon. PW-18

Opportunity in city of 5,000 population located in Northeast Alabama in trade area of approximately 10,000 population. Office space available. One physician died recently. Hospital and nursing home in the city. PW-19

Special Openings—

Specialist in the following fields: Internal Medicine, Pediatrics, Obstetrics-Gynecology and General Practitioners. 58-bed fully accredited general hospital with 91-bed addition recently completed. Modern new office space available. PW-20

Opportunity for general practitioners or internists for institutional practice at TB Sanatorium in North Alabama. PW-21

Opportunity for physician interested in joining a progressive public health tuberculosis control program working in Birmingham, Jefferson County. Provide outpatient medical services and some administrative duties. Fringe benefits and salary open. PW-22

Student Health—

New 75-bed facility to be occupied in late 1968. Present staff of seven full-time physicians. Salary negotiable. Appointments are full time with regular University benefits. PW-23

Full time salaried position of assistant director on staff of four 65-bed well equipped infirmary with adequate office space. Excellent laboratory and X-ray facilities. Liberal fringe benefits. PW-24

Obstetrician-Gynecologist—

Excellent opportunity for a trained Ob-Gyn man who would join a three-man partnership practice in city of 30,000 population located in southwest Alabama. Salary is proposed for the first 12 months, a limited partnership to begin at the end of twelve months, and full partnership to begin at the end of 24 months. PW-25

Statistics Sought on Cancer Family Syndrome

The Medical Genetics Section of the Department of Preventive Medicine and Public Health at Creighton University School of Medicine, Omaha, Neb., is interested in the study of patients showing an increased incidence of any histological variety of cancer in their families.

Of particular interest to us is the cancer family syndrome, characterized by: 1) increased frequency of adenocarcinoma of all sites, particularly of the colon and endometrium, 2) early age at onset of cancer, 3) increased occurrences of multiple primary malignant neoplasms, and 4) autosomal dominant inheritance. To date, we have investigated six families fulfilling all of the above criteria (Lynch, H. T., and Krush, A. J.: Heredity and Adenocarcinoma of the Colon, *Gastroenterology* 53:517-527, 1967), and have corresponded with physicians in Europe who have described two separate and non-related families which also fulfill the above criteria.

Physicians with patients known to have a familial cancer background, may write to Henry T. Lynch, M. D., Associate Professor and Chairman, Department of Preventive Medicine and Public Health, Creighton University School of Medicine, 657 North 27th Street, Omaha, Nebraska 68131.

We invite your cooperation in our studies which will include a genealogical and medical investigation of the entire kindred in each case. All information obtained will be shared with family physicians in order to facilitate cancer control.



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Warning: Although generally safer than the amphetamines, use great caution when prescribing for patients with severe hypertension or severe cardiovascular disease. Should not be used during the first trimester of pregnancy unless potential benefits outweigh potential risks.

Side Effects: While rarely causing therapy to be withdrawn, side effects may occur occasionally; CNS effects (such as insomnia, nervousness, jitteriness), dryness of mouth, thirst, nausea, abdominal distress, constipation, headache, allergic response including urticaria or other dermatitis; rarely associated with tachycardia, cardiac arrhythmia or ECG changes.

Convenience of two dosage forms: TEPANIL Ten-tab tablets: One 75 mg. tablet daily, swallowed whole, in midmorning (10 a.m.); TEPANIL: One 25 mg. tablet three times daily, one hour before meals. If desired, an additional tablet may be given in midevening to overcome night hunger.

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Make No Mistake About It: Air Pollution Is A Health Problem

The January issue of *Today's Health* features a photograph of St. Louis's Gateway Arch, curving into the sky line a vast croquet wicket above the bank of smog under which downtown St. Louis is buried.

The picture illustrates the report of an AMA-sponsored Air Pollution Medical Research Conference in Denver, where experts reported that soot and ash shrouding America's industrial cities seem prime factors in the increased incidence of stomach cancer in older persons, and that atmospheric carbon monoxide is clearly associated with death from myocardial infarction.

Coming at the same time as the published details of the air-pollution bill to be given the Alabama Legislature next May, with the proposed composition of the Air Pollution Control Commission, the Medical Association of the State of Alabama, the Legislature and the public generally must face the question:

"Is air pollution a health problem?"

Answer that question in any way *but* the affirmative, and you are immediately and rightly suspect. If there are those who believe it is *not* a health problem, then the interim legislative committee's proposal to stack the commission on the side of business, industry and politics is understandable.

As it stands now, the Commission would be composed of ten members, with the State Health Officer as "ex officio" (or non-voting) member and chairman.

Three of the remaining nine will be business and industry oriented, one each from the Associated Industries of Alabama, the Alabama Mining Institute, and the Alabama State Chamber of Commerce. Three are "representatives of the public," one each from names chosen by the Alabama League of Municipalities, the Alabama Association of County Commissioners, and from the engineering faculty of either Auburn or the University of Alabama. And three will be licensed physicians from a list submitted by the State Board of Health.

If air pollution *is* a health problem—and who could seriously challenge the point?—then the interim legislative committee which drafted the bill may find it difficult to defend the 5-to-4 lineup of the Air Pollution Control Commission as in the best interests of the people of Alabama.

Let every physician remember that the Medical Association of the State of Alabama *IS* the Board of Health.

Since every physician is a member of the Board of Health, it is his responsibility, individually and collectively, to support:

Effective and Positive Air Pollution Control Legislation.

As his personal responsibility, every physician in Alabama should make his thinking known to his county's legislators.

The weak and ineffective "Water Pollution Control"—even including the "grandfather clause" which stretches a "reasonable length of time" to seven years of grace for established industries to continue contamination—must not be xeroxed for Air Pollution Control.



Head-acres?

Now... a welcome refuge from tension as well as pain



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Dialog could be a suburban wifesaver.

INDICATIONS: Relief of pain and discomfort of simple headache; neuralgia, myalgia, and musculoskeletal pain; dysmenorrhea; bursitis; sinusitis; fibrositis. Also to relieve discomfort and reduce fever caused by respiratory infections, influenza, and other febrile conditions.
CONTRAINDICATIONS: Sensitivity to any of ingredients and moderate to severe hepatic disease.
WARNINGS: May be habit forming. Dosage of coumarin anticoagulants may require adjustments during and on cessation of therapy.
Use in Pregnancy
Safe use in pregnant women, or during lactation, has not been established. Therefore, benefits must be weighed against potential hazards.
PRECAUTIONS: Periodic CBC is advised during prolonged therapy.
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DOSAGE AND ADMINISTRATION
Adults: One or 2 tablets q 4 h, not to exceed 8 tablets in 24 hours.
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SUPPLIED: Tablets (white, scored), each containing 15 mg allobarbital and 300 mg acetaminophen; units of 3 bottles of 30.

Consult complete literature before prescribing.

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Now Could Be A Good Time To Foster Euthanasia Bill

In the closing days of World War I an American destroyer lay anchored in the Mersey Estuary, off Liverpool. Nearby was a British warship, which without warning was shaken by an explosion.

The American weighed anchor and moved in closer to render what assistance it could.

As it neared, two men were brought to an upper deck of the Britisher, writhing and screaming with agony. The stretcher-bearers set them down. The ship's doctor adjusted a hypodermic needle and injected its contents, into first one and then the other of the two. They promptly subsided into death.

Years later, recalling the incident, a retired naval officer from Mobile confidently expressed the opinion that he had witnessed euthanasia, and his admiration was all for the doctor who had had the courage to practice it.

In principle, almost any understanding human being would applaud the act. And if it ever came to a vote, it is probable every M. D. would vote for it, while at the same time flinching (if you'll forgive the generalization) from personal responsibility.

In that connection, it is interesting to find how the late Archbishop of Canterbury reasoned, when a bill to legalize euthanasia in England came before the House of Lords.

The bill would permit the attending physician, in the case of an agonizing and incurable illness, to administer a lethal dose—with the patient's consent of course.

And it was on that latter ground that the Archbishop of Canterbury, the primate of all England, directing head of the Church of England, opposed and defeated it. The patient's consent, he reasoned, turns euthanasia into suicide. And suicide is sin!

As Sir Bertrand Russell reported it: "Their Lordships listened to the voice of authority and rejected the bill."

The weight of religious opinion will generally be found in opposition to it. For example, in his "Concise Dictionary of Judaism," Dagobert Runes says, under *Euthanasia*, "Disapproved by spirit of Jewish law."

But isn't now a proper time to commend it to the attention of thoughtful members of the Alabama Legislature?

A Walking Corpse? Or Blind To Reason?

"The man without faith is a walking corpse," Pope Xystos I said, a century and a half after Christ.

And sixteen centuries later, "Poor Richard" observed slyly in his Almanac: "The way to see by faith is to shut the eye of reason."

Somewhere between these two extremists is the common man of today.

Faith is what two drivers possess when their cars pass on a narrow road, barely two feet apart, and each traveling 60 miles an hour.

Faith puts potency into a sugar-pill.

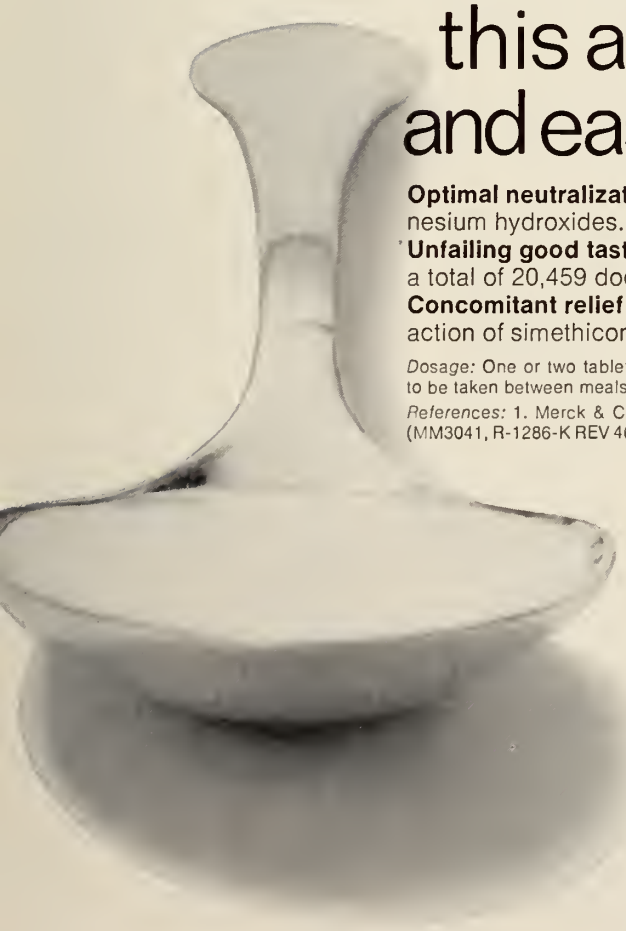
Faith rides alike at the controls of a commercial airplane and in the passenger seats behind it.

Faith joins a book-selection club, swallows a pharmacist's preparation, buys a well-publicized toothpaste, rides a ski lift high in the sky, suspended from a steel thread, and leads two almost-strangers to the altar where they promise to love, honor and cherish—" 'till death do us part."

Faith climbs the slender scaffold, walks the

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Optimal neutralization[1] — provided by the combination of aluminum and magnesium hydroxides.

Unfailing good taste — confirmed by 87.5% of 104 patients in one study, after a total of 20,459 documented days on Mylanta Liquid or tablets.[2]

Concomitant relief of G. I. gas distress — provided by the proven antiflatulent action of simethicone[3].

Dosage: One or two tablets (well chewed or allowed to dissolve in the mouth); one or two teaspoonsful to be taken between meals and at bedtime, or as directed by physician.

References: 1. Merck & Co., Merck Chemical Division: Antacid Literature Survey, Rahway, New Jersey. (MM3041, R-1286-K REV 463.) 2. Danhof, I.E., report on file. 3. Hoon, J.R.: Arch. Surg. 93:467 (Sept.) 1966.

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Huge 60-Block Complex To House University In Birmingham

Size of the University of Alabama in Birmingham is to be quadrupled, and the initial step in that direction has been taken with a grant of $11,479,472 to the Housing Authority of Birmingham for acquisition of 241 acres adjacent to the present site of the school.

Transformed, the present 15-square-block campus housing the Medical Center and the College of General Studies will become a huge 60-block complex on Birmingham's Southside.

The Housing Authority has worked for several years with the city of Birmingham, interested citizens and HUD to secure the renewal funds.

Dr. Joseph F. Volker, UAB executive vice president, cited the Housing Authority grant as a splendid example of strong public support of the activities and expansion plans of the UAB.

"This award is one of the most significant developments in Birmingham's history," he said. "The educational and economic benefits to the city and the state will be enormous."

One of the first priorities for use of the new land will be a new complex for the College of General Studies, Dr. Volker said. Since the CGS was inaugurated in 1966, its student population has increased steadily, and, by 1978, an enrollment equivalent to 15,000 full-time students is expected.

Dr. Volker expressed hope that at least one new building for the CGS will be constructed each year for the next five years.

Long range plans for expansion of the Medical Center facilities in the urban renewal area include such facilities as a new University Hospital—No. 2, a cardiovascular hospital, a diabetes center, a cancer hospital, a genetics center, a burn hospital, a Regional Technical Institute, the North Central Alabama Rehabilitation facility and a student union, as well as many other health related facilities.

Housing Authority executive director Hugh Denman said that purchase of land in the area can begin within the next 30 to 45 days.

"We will cooperate with University officials in trying to make available to them first the pieces of property which they need most," Denman said.

"We can make the property available gradually as we gain title to it, rather than waiting and making it available all in one package."

Included in the award were funds for relocation of some 996 families and 120 business establishments now located in the area.

Included in the Medical Center construction projects now underway are a new $15 million Basic Sciences Building, a $1.4 million Medical Center Library, a $2 million School of Nursing, a Computer Research Center, University Hospital South Wing, a Jefferson County Mercy Hospital and a Center for Developmental and Learning Disorders.

Additions to the Spain Rehabilitation Center and the Children's Hospital located in the complex are also being built at this time.

Calendar of Annual Meetings

Medical Association of the State of Alabama

1969, April 24-26, Carriage Inn, Huntsville

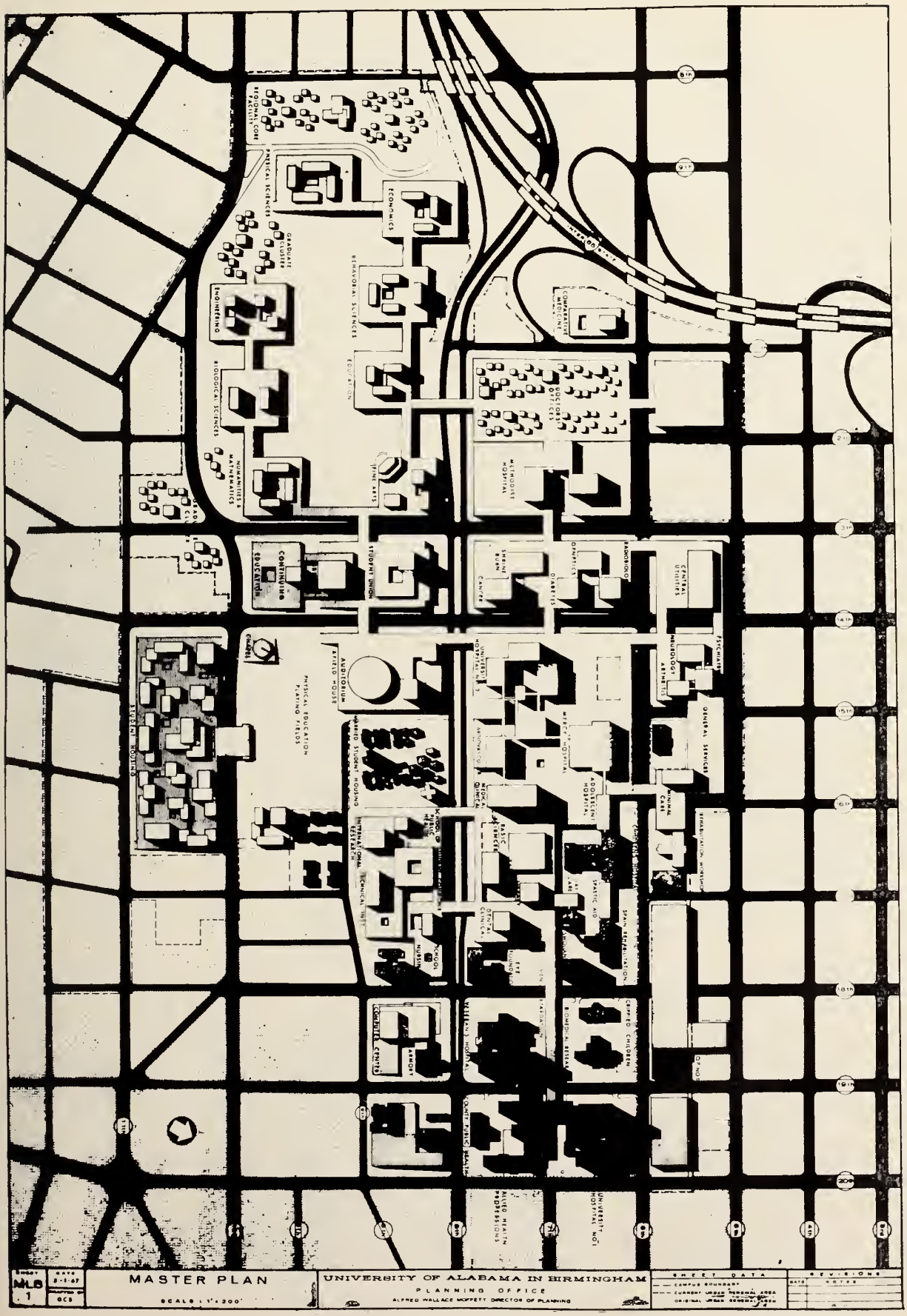
1970, April 30-May 2, Mobile

1971, April 22-24, Birmingham

1972, April 20-22, Montgomery

1973, April 18-21, Mobile

University's Birmingham Medical Complex To Be Quadrupled In Size



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Adverse Reactions: Drowsiness; excessive dryness of nose, throat or mouth; nervousness; insomnia. Other known possible adverse reactions of the individual ingredients: nausea, vomiting, diarrhea, rash, dizziness, fatigue, tightness of chest, abdominal pain, irritability, tachycardia, headache, incoordination, tremor, difficulty in urination. Thrombocytopenia, leukopenia and convulsions have been reported.
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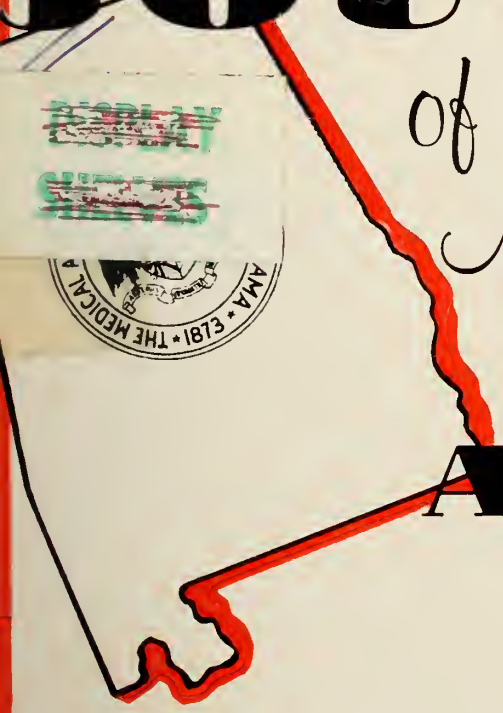
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Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma.
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.
Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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Before prescribing, see complete prescribing information in SK&F literature or *PDR*.
Contraindications: Hyperexcitability, undue restlessness, hyperthyroidism, porphyria; in patients on MAO inhibitors.
Precautions: Use with caution in patients hypersensitive to sympathomimetics or barbiturates and in coronary or cardiovascular disease or severe hypertension. Excessive use of the amphetamines by unstable individuals may result in a psychological dependence. Rarely, symptoms of toxic psychosis (hallucinations, confusion, panic states, etc.) may occur with amphetamines, usually after prolonged high dosage. In these instances, withdraw the medication. Use cautiously in pregnant patients, especially in the first trimester.
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(Term: January 1, 1968-December 31, 1969)

Delegate—Paul W. Burleson, M. D. ..... Birmingham
(Term: January 1, 1968-April 26, 1969)

Delegate—E. Bryce Robinson, M. D. ..... Fairfield
(Term: January 1, 1968-December 31, 1970)

Alternate—Robert Parker, M. D. ..... Montgomery
(Term: January 1, 1968-April 26, 1969)

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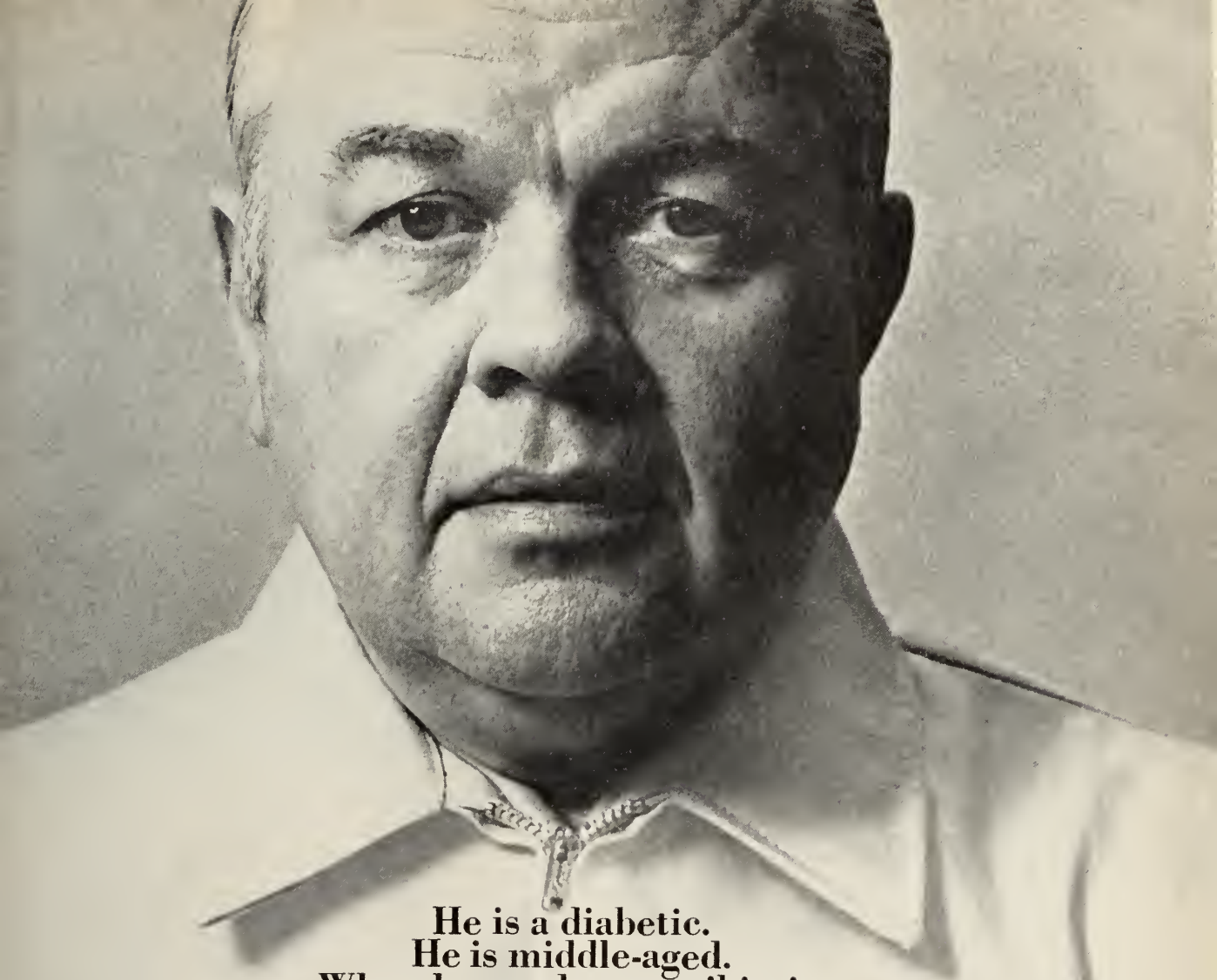
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He is a diabetic.
He is middle-aged.
When he needs an antibiotic
he may be a candidate for

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Demethylchlortetracycline HCl 300 mg and Nystatin 500,000 units CAPSULE-SHAPED TABLETS Lederle

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guard susceptible patients against intestinal monilial overowth during broad-spectrum therapy—the protection of ystatin is combined with demethylchlortetracycline in ECLOSTATIN.

For your susceptible candidates, prescribe DECLOSTATIN the broad-spectrum therapy that prevents monilial ergrowth.

fectiveness: Because its antibacterial component is DECLOMYCIN emethylchlortetracycline, DECLOSTATIN should be equally or more ective therapeutically than other tetracyclines in infections caused by racycline-sensitive organisms. The antifungal component, Nystatin, otects against superinfection by antibiotic-resistant fungal overgrowth articularly monilia) in the intestinal tract.

ntraindication: History of hypersensitivity to demethylchlortetracyne or nystatin.

rning: In renal impairment, usual doses may lead to excessive accumtion and liver toxicity. Under such conditions, lower than usual doses e indicated, and, if therapy is prolonged, serum level determinations y be advisable. A photodynamic reaction to natural or artificial sunht has been observed. Small amounts of drug and short exposure may oduce an exaggerated sunburn reaction which may range from erytema to severe skin manifestations. In a smaller proportion, photoergic reactions have been reported. Patients should avoid direct posure to sunlight and discontinue drug at the first evidence of skin scomfort. Necessary subsequent courses of treatment with tetracynes should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg h.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

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President's Page



E. L. McCafferty, Jr.

In a short time the annual meeting of the Medical Association of the State of Alabama will convene in Huntsville. We have arranged a scientific program that I hope will be of general interest to most of you, and a social program that will be fun for everyone.

Besides the scientific and social programs, I would like to emphasize the business meeting that will take place on Saturday morning, and urge each of you to inform yourselves regarding the issues that will come to the floor so that our Association may have the conclusions of your considered judgment. The Board of Trustees and the Board of Censors as well as your general officers are available throughout the year to hear your requests or recommendations. However, the annual meeting is the only time we gather as an Association to review the reports of the committees and the actions taken by your general officers. This is the time that ideas can be presented, sifted, and conclusions reached with the least possible effort, and I hope that each Counsellor and Delegate will participate fully in the discussions that will come before our Association at this time.

I would also urge that each County Society make every effort to have a full representation at this meeting, the Counsellors, the Delegates, and the Alternates, so that your wishes can be adequately expressed in areas involving both the internal and external operations of our Society.

It is also well to keep in mind that shortly the State Legislature will meet in Montgomery, and it is amazing when we contemplate how much of the legislative action will in one way or another touch the medical profession in our efforts to promote better health for the people in this state. The medical profession singly and collectively is involved and should be concerned in all of the elements that influence the lives of our people, and in this sense should be even more interested in legislation than a lay citizen with a more limited interest.

As you are aware, legislation will be introduced to implement Title XIX. This program is estimated to involve the expenditure of one hundred and eight million dollars and to eventually comprise approximately 40 per cent of your practice. This is a tremendous program and if it is to work, one that will require the cooperation and efforts of all of the physicians in this state.

The educational program for medical students is another example of the wide range of interests that will be explored during the next legislative session. The fact that there is already a shortage of physicians in the rural areas which in time will extend to urban

areas makes it mandatory that we interest ourselves in this area.

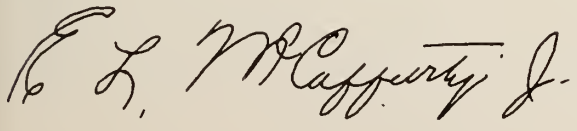
In a recent meeting of over 4,000 scientists the two most pressing problems involving the future of the world were considered to be population and pollution.

Although we thrill to the exploits of the astronauts and in time their exploration into space will have practical application, the time is now and on this earth that we must face the problems of a better world for our children and plan wisely to provide them with an environment to live happy and useful lives.

The interest and responsibilities of the Medical Association of the State of Alabama are so involved and increasing so rapidly in scope that we as an Association cannot hope to solve them alone, but we can hope to contribute the conclusions that our collective thinking as related to the areas in which we live and practice and in the end find some accommodation within the changing times.

As we assume these new interests and if we hope to be a contributing influence, then it seems to me that we should call our entire Association in general assembly more often than annually. There are two reasons for my asking you to consider additional state meetings. The first, of course, is to be thoughtfully aware of the problems that exist, and secondly, to form a positive attitude to contribute toward their practical solutions.

To be involved is a popular cliche that is being widely accepted as a social responsibility by many lay people without any particular experience or knowledge, and the job goes on, but think of the considerable contribution the medical profession is potentially capable of making if we as members of the team contributed our share to its utmost capability. This we can do, and this I hope will do to a greater degree in the future than in the past.



New York City Is Site of AMA'S 1969 Annual Convention

New York City is the site of the American Medical Association's 118th Annual Convention, July 13 through 17.

The nation's largest city has been host to two AMA annual conventions in this decade —in 1961 and 1965—and attendance at each exceeded 60,000.

A total registration of 60,000 is predicted for the 1969 convention, including some 22,-500 physicians. Medical students, nurses and other members of allied medical professions, industrial exhibitors, and guests make up the rest of the registrants.

Four general scientific sessions are planned:

* Human Sexuality
* Physical Fitness and Aging
* Impact of Medical Education on Patient Care
* Chronic Pulmonary Insufficiency and Air Pollution Problems

Each of 22 scientific sections also will present a program. The 23rd section—on special topics—plans six sessions:

* Drug Utilization (in cooperation with AMA's Council on Drugs)
* Mental Health Dynamics in the Pre-School Child (in cooperation with AMA's Council on Mental Health)
* Disaster Planning for Aviation Accidents (in cooperation with AMA's Committee on Disaster Medical Care)
* Neurological Surgery
* Nuclear Medicine
* Plastic and Maxillofacial Surgery

The May 26 issue of The Journal of the American Medical Association will list the entire scientific program.

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Adverse Reactions:
Due mainly to anticholinergic action and usually at high dosage. They may include dryness of the mouth, tachycardia, palpitation, urinary hesitancy or retention, blurred vision, dilatation of the pupil, increased ocular tension, weakness, nausea, vomiting, headache, dizziness, constipation and drowsiness. Infrequently, mental confusion in the elderly, urticaria or other dermatoses. Adverse reactions are usually eliminated by reduction in dosage. Two cases of aplastic anemia, with no established causal relationship, have been reported.

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War's End Shrinks Roll Of Medical College Graduates

There've been two world wars in this 20th century, often interrupting or postponing the medical education of young Alabamians. As evidenced by at least the first of these two wars, the roll call of medical college graduates shrivels to its lowest ebb in the year after war's end.

Which is why this year's additions to the Medical Association's 50-year club total two. Originally there were four, but death halved that figure.

The two to whom recognition will be formally accorded at the April meeting of the Medical Association of the State of Alabama are Dr. Beverly Woodfin Cobbs of Montgomery, who was graduated from Tulane with his M. D. degree, and Dr. William Grover Shamblin of Tuscaloosa, whose degree comes from the University of Alabama, both dated 1919.

The two who, had they lived would have joined Drs. Cobbs and Shamblin, are Dr. Ernest Clark Pope of Birmingham, an Emory graduate, and Dr. Eugene Heriot Dibble of Tuskegee Institute, a graduate of Howard.

Contrast the two receiving recognition with the six in 1968, the twelve in 1967 and in 1966, the thirteen in 1965, and the sixteen in 1964.

Next year there will be ten Alabama doctors eligible for membership in the 50-year Club of the Medical Association, and their biographical sketches will be appearing in the Journal in the months between the annual convention of 1969 and that of 1970.

The Woman's Auxiliary

President, Mrs. R. K. Wilson, Sr.
President-Elect, Mrs. B. H. Johnson, Jr.
Northeast District Vice President, Mrs. Eugene H. Bradley
Northwest District Vice President, Mrs. Gene Qualls
Southeast District Vice President, Mrs. George Andrews
Southwest District Vice President, Mrs. G. William Wiles
WAMASA Editor, Mrs. William L. Smith

AUXILIARY PLEDGE

"I pledge my loyalty and devotion to the Woman's Auxiliary to the American Medical Association. I will support its activities, protect its reputation and ever sustain its high ideals."

January has been a particularly busy month, as I have visited in many Auxiliaries in various parts of the state. Some of our Auxiliaries have as few as five members, while the largest one is composed of more than 300 members, so the problems and the projects differ widely. I have found, however, that we share one common goal: to be of service in our communities as doctors' wives, as we strive to bring about a closer fellowship between the families of the doctors in our respective counties.

My first visit in January was to Fort Payne, to attend a Luncheon, at the meeting of the DeKalb County Auxiliary on January 6. The following day, I was in Vernon, as a guest of Lamar County. I was the speaker in Enterprise, Coffee County, at 10:30 A. M. on January 17, and in Ozark, Dale County, at 2 P. M. the same day. On January 21, I attended a Luncheon meeting in Anniston, Calhoun County; the Jefferson-Bessemer meeting was held on January 23 in Bessemer. In my appointment book, there is just one more county to visit this month, Walker County, on the 28th. There will be an Executive Board meeting on January 30, where final plans for the state Convention will be discussed, and other matters of business brought up. As I have visited the Auxiliaries this month, much interest in the Convention in Huntsville has been evident, and it seems that the attendance will be very good.

I would like to urge you, once again, to participate in the Exhibits at the Convention, and to bring your hobbies for display. The Archives and Exhibits chairman, Mrs. William B. Cameron, 109 Nolen Circle, S. E., Huntsville 35801, hopes to have many doctors' families included in this Exhibit. These are not only interesting to see, but may be instrumental in inspiring others to develop a hobby. Also, please urge your wives to attend the Auxiliary sessions, and to join us in the Luncheon and Fashion Show, the tour of antebellum homes, and the tour of the Space Center.



Mrs. Robert K. Wilson, Sr.

It will soon be time for reports from the local Auxiliaries, and they will be most interesting to read. Reflected in these reports, however, will be much more than numbers and statistics. They will represent the spirit, the genuine concern and the deep involvement of the members throughout the state.

Louise M. Wilson

(Mrs. Robert K. Wilson, Sr.)
President, WAMASA

Medical Association's Auxiliary Has Ambitious Huntsville Program

A grand tour of the "Space Capital of the Universe" is a highlight in the 45th annual convention of the Woman's Auxiliary to the Medical Association of the State of Alabama. And, as the tour capacity is 200, those anxious to be assured of a place in it should take advantage of the pre-convention registration at Carriage Inn from noon to 4 p. m., Wednesday, April 23rd. There is a registration fee of $2 for the convention.

A pre-convention executive board meeting will be held that afternoon at the Sheraton Motor Inn, Huntsville, from 2:30 to 4:30.

Call to order and welcome—Mrs. Robert K. Wilson, Sr.

Invocation—Mrs. Robert E. Stewart.

THURSDAY, April 24th

8 a. m-5 p. m.—Registration—Carriage Inn, Exhibit Area, Registration fee $2.

8 a. m.—Continental Breakfast, Sheraton Motor Inn, State Room.

8:15—First General Session and Continuation of Continental Breakfast, Sheraton Inn, State Room.

Call to Order—Mrs. Robert K. Wilson, Sr.

Invocation—Mrs. Robert E. Stewart.

10:45—Recess.

1:00-12:45—Luncheon, Sheraton Motor Inn, Grand Ballroom.

In keeping with this sesquicentennial year of Alabama's statehood, there will be a fashion show portraying historic Huntsville, the first state capital. Models and fashions will portray the history of Huntsville from that distant day to now, when Huntsville is the "Space Capital of the Universe."

1 p. m.—Board buses at Carriage Inn for Marshall Space Flight Center.

Thursday is the deadline for Entries and Exhibits, a show open to members, husbands and children, for displaying talents in Photography, Arts, Crafts, Hobbies and Collections. These entries should be brought to the Exhibit area outside Carriage Inn.



WAMASA OFFICERS:—From left, Mrs. Ben Johnson, president-elect; Mrs. H. Mack Pewitt, co-chairman, state convention; Mrs. Robert H. Boon, general chairman; Mrs. Robert K. Wilson, Sr., president.

FRIDAY, April 25th

8 a. m.-2 p. m.—Registration, Carriage Inn, Exhibit Area.

9 a. m.—Board buses for Heritage Tour, Sheraton Motor Inn.

This tour will be through the old Twickenham section of Huntsville with visits in several antebellum homes, some built, occupied or presently the homes of physicians.

11:45 a. m—Return to hotel.

12:30 p. m.—ALAPAC Luncheon.

2-4 p. m.—Second General Session, Sheraton Motor Inn, State Room.

Call to order—Mrs. Robert K. Wilson, Sr.

Invocation—Mrs. Robert E. Stewart.

Adjourn Convention, Mrs. Robert K. Wilson, Sr.

4-5:30 p. m.—Post-convention Workshop, Sheraton Motor Inn, State Room.

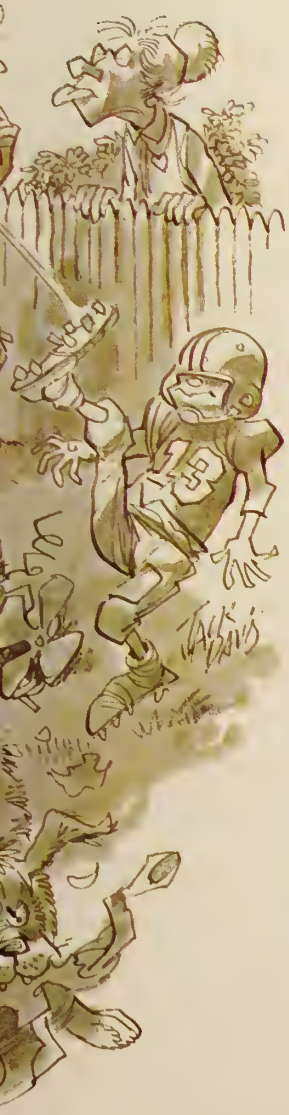
SATURDAY, April 26th

9 a. m.—Meeting with Medical Association of the State of Alabama, Carriage Inn.



Head-acres?

Now... a welcome refuge from tension as well as pain



Split-level tensions build up to splitting headaches.

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Dialog could be a suburban wifesaver.

INDICATIONS: Relief of pain and discomfort of simple headache; neuralgia, myalgia, and musculoskeletal pain; dysmenorrhea; bursitis; sinusitis; fibrositis. Also to relieve discomfort and reduce fever caused by respiratory infections, influenza, and other febrile conditions.
CONTRAINDICATIONS: Sensitivity to any of ingredients and moderate to severe hepatic disease.
WARNINGS: May be habit forming. Dosage of coumarin anticoagulants may require adjustments during and on cessation of therapy.
Use in Pregnancy
Safe use in pregnant women, or during lactation, has not been established. Therefore, benefits must be weighed against potential hazards.
PRECAUTIONS: Periodic CBC is advised during prolonged therapy.
ADVERSE REACTIONS: Side effects are rare. Nausea, transitory dizziness, anuria, and rash may occur. Overdosage of allobarbital will produce symptoms of barbiturate excess.
DOSAGE AND ADMINISTRATION
Adults: One or 2 tablets q 4 h, not to exceed 8 tablets in 24 hours.
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Editorial COMMENT

The Public Too Needs A Better Medical Image

The graven image of our time is the creation of a "good press."

It was a "good press" in the person of the British artist, Sir Luke S. Fildes, who in 1892 created "The Doctor," that immortal picture that once graced every doctor's waiting room in the civilized, English-speaking world.

And it is the absence of that "good press" that has permitted the image of the concerned family physician to fade in the shadow of specialization and the computer. The public has forgotten and it is not the public's fault.

Some may remember vaguely. Beside a dining table that bore a lamp and a coffee cup, sat a bearded, frock-coated doctor, his chin in his hand, looking down at a little girl stretched on two pillow-padded, mismatched dining-room chairs, obviously in a coma and apparently in a pneumonia crisis; in the background the mother bent over another table, her head in her arms, while the father stood beside her, his hand on her shoulder.

The loss of that vanished image is not alone the loss of the medical profession. It is the loss of everyone who craves human sympathy and understanding. And the recovery of it might be accomplished by emphasis on the countless passing incidents where a doctor has stepped from behind his impersonal, imperturbable mask, to let his concern show momentarily.

The other day, while patients in a crowded waiting room sat, a north Alabama doctor called the Association building, to ask a question:

"Is there an Arizona charity hospital, specializing in respiratory diseases, that will take an acutely asthmatic child?"

In this simple question and the facts behind it lie the possibility of another "graven image," challenging the ingenuity, imagination and inspiration of a present-day artist such as Sir Luke Fildes.

The patient—A 17-year-old boy, who looks no older than 9, wracked from babyhood by acute paroxysms of asthma; the son of indigent parents living on relief.

The doctor: A busy general practitioner in a community of under 7,000, concerned over a "case" that could mean nothing to him in money or status, finding a hospital bed for the boy whenever attacks became frighteningly acute, taking him to Birmingham to see what the Medical Center could do for him, and making long-distance telephone calls as though they were free.

The situation: Failing to find a place for his patient in any of the three Arizona hospitals suggested by MASA, he telephoned Denver and talked with the administrator of the Children's Asthma Research Institute and Hospital and the Jewish National Home for Asthmatic Children.

Whether or not the boy survives his most recent smothering spell, while formal applications are being filed in Denver for him, this is the kind of incident that needs publicizing. It is an incident being duplicated essentially in every community in the nation, forgotten as soon as it occurs.

But these are incidents that, cumulative, provide as excellent materials for creating a "graven image" of the medical profession, as the jewelry of the Israelites in the desert served to create the golden calf.

The public needs that image, as certainly as does the medical profession.

Infant Mortality Rises As Man's Longevity Retreats

Complacency in the face of impending disaster seems to be a characteristic common to the present-day American. Health statistics are a glaring example.

For years, while advances in medical science and the laboratory have been sensational, the shortage of M. D. graduates was increasingly apparent. Medical college enrollment has not kept pace with the population explosion, and the concern is reflected in special inducements to graduate doctors, including forgiven medical-college loans.

But another and more frightening avenue of evidence is opening with the statistical tables on life expectancy in the United States. Reaching the Biblical "three score years and ten" in 1963, the climb has not only ground to a crawl since then, but there is evidence that man's life expectancy since then has actually begun a retreat from that high point of five years ago.

The death rate for the male of the species has been rising steadily, from diabetes, respiratory disease, and some forms of cancer.

More than that, the infant mortality rate in this country does not compare well with Japan and the Netherlands. As Victor Fuchs, economist for the National Bureau of Economic Research, wrote recently in the New England Journal of Medicine:

"The relatively high infant mortality rate in this country is disturbing and difficult to understand. The disparity in death rates for middle-aged males is even more shocking and has more serious economic implications."

Dr. John H. Knowles, general director of Massachusetts General Hospital, Boston, went even further, commenting: "It's wild. Every city has health statistics that look worse than some of those of the less-developed countries. No matter how fine a teaching institution we have here for doctors, our problem is still how to get care that we already know about delivered to people who need it."

Paralleling this retreat from a proud health position in this country are the multiplying millions and billions being spent in this country on research and education, health insurance and health care, on medicare and medicaid.

A disturbing facet is the skyrocketing cost of hospitalization. While consumer prices in the years since World War II have risen by some 71 per cent, hospital service charges have increased in the same period by 441 per cent.

Comments the National Observer editorially:

"The situation is chaotic. Costs are soaring with no end in sight. And yet the nation's health seems to be no better than it was before all the money was available to pay the bills. . . Professionals in the field seem reduced to handwringing."

Such is the situation confronting a new President, as it will continue to confront every county medical society in the state, and every state medical association in the nation.

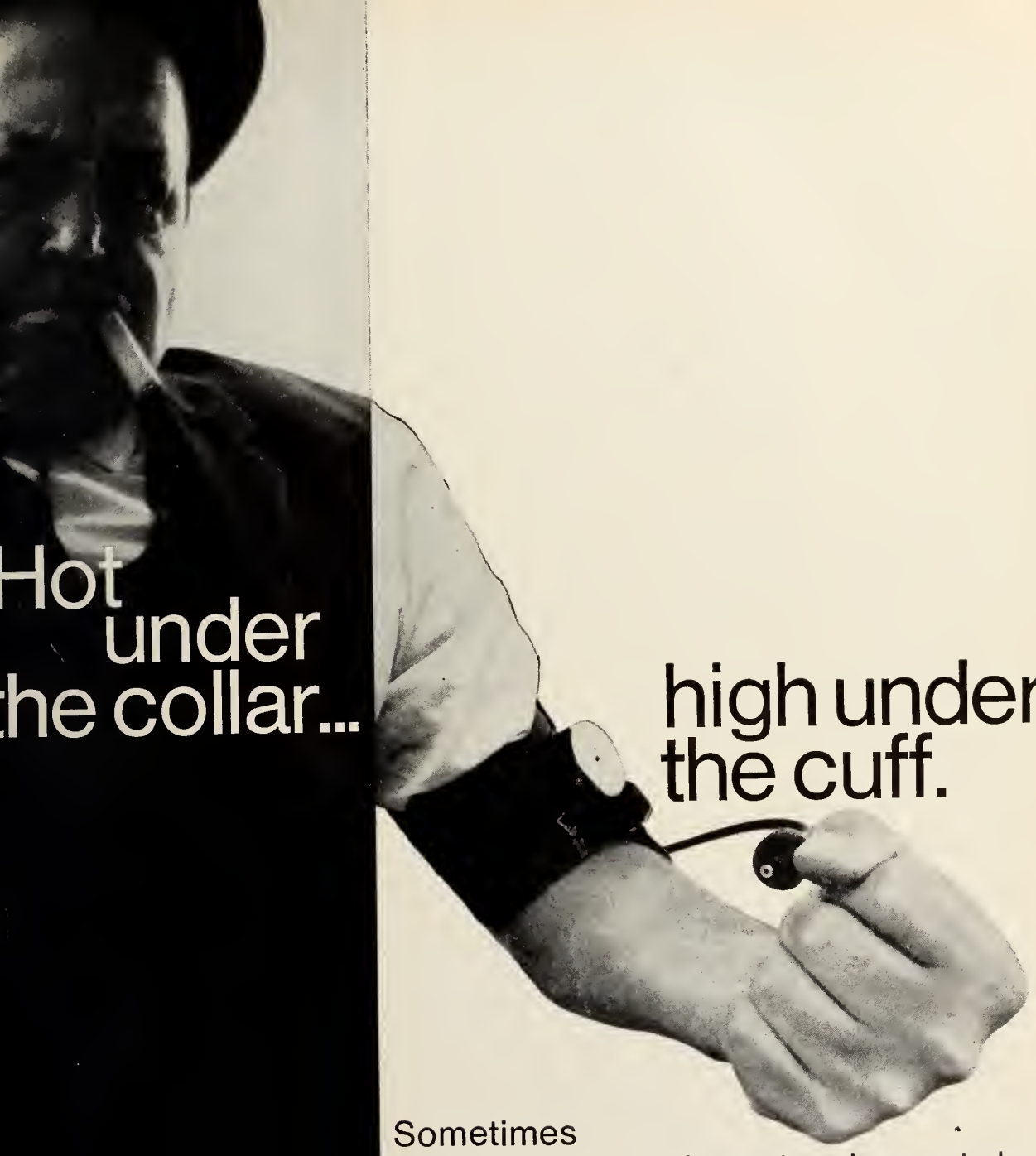
We are the greatest state in the greatest nation on the face of the earth. The fact is axiomatic. We have come to believe it.

And rightly so. It is the stuff of which patriotism is made.

In the all-out assault on this nation from the inside, our faith has been the weak link in our defenses—faith in our state and in our country, faith in ourselves and in our God.

It has taken no massive conspiracy led by intellectual giants to make us meek. All that has been necessary is the planting of seeds of doubt. Sow a lot of question-marks around

(Continued on Page 785)



Hot
under
the collar...

high under
the cuff.

Sometimes
he forgets he has hypertension, gets hot
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patients, consider **Regroton®**

chlorthalidone	50 mg.
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To lower blood pressure
and allay anxiety in hypertension.

For brief summary of prescribing information, see next page.

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reserpine U.S.P. 0.25 mg.

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Regroton is a combination of two basic antihypertensives designed to lower blood pressure and allay anxiety in hypertension. With Regroton he can keep his shirt on and you can keep his blood pressure down.

Before prescribing, please review carefully the indications, contraindications, warning, precautions, adverse reactions and dosage information below.

Regroton®
Each tablet contains:
chlorthalidone 50 mg.
reserpine U.S.P. 0.25 mg.

Indications: Hypertension.
Contraindications: History of mental depression, hypersensitivity, and most cases of severe renal or hepatic diseases.
Warning: With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small-bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has frequently been required and deaths have occurred. Discontinue coated potassium-containing formulations immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Discontinue one week before electroshock therapy, and if depression or peptic ulcer occurs.
Use in pregnancy: Because chlorthalidone may cross the placental barrier and appear in cord blood and thiazides may appear in breast milk, this drug should be used with care in pregnant patients and nursing mothers. When used in women of childbearing age, the potential benefits of the drug should be weighed against the possible hazards to the fetus. Use of chlorthalidone may result in fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult. Increased respiratory secretions, nasal congestion, cyanosis and anorexia may occur in infants born to reserpine-treated mothers.
Precautions: Antihypertensive therapy with this drug should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents, other potent antihypertensive drugs, or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. To avoid hypotension during surgery, discontinue therapy with this agent two weeks prior to elective surgical procedures. In emergency surgery use, if needed, anticholinergic or adrenergic drugs or other supportive measures as indicated. Because of the possibility of progression of renal damage, periodic kidney function tests are indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated. Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, the drug should be discontinued and potassium supplements given, provided the patient does not have marked oliguria.
Take particular care in cirrhosis or severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Severe salt restriction is not recommended. Use cautiously in patients with ulcerative colitis or gallstones (biliary colic may be precipitated). Bronchial asthma may occur in susceptible patients.
Adverse Reactions: The drug is generally well tolerated. The most frequent side effects are nausea, gastric irritation, vomiting, diarrhea, constipation, muscle cramps, headache, dizziness and acute gout. Other potential side effects include angina pectoris, anxiety, depression, bradycardia and ectopic cardiac rhythms (especially when used with digitalis), drowsiness, dull sensorium, hyperglycemia and glycosuria, hyperuricemia, lassitude, restlessness, transient myopia, impotence or dysuria, orthostatic hypotension which may be potentiated when chlorthalidone is combined with alcohol, barbiturates or narcotics, leukopenia, aplastic anemia, skin rashes, thrombocytopenia, agranulocytosis, nasal stuffiness, increased gastric secretions, nightmare, purpura, urticaria, ecchymosis, weakness, uveitis, optic atrophy and glaucoma, and pruritus. Eruptions and/or flushing of the skin, a reversible paralysis agitans-like syndrome, blurred vision, conjunctival injection, increased susceptibility to colds, dyspnea, weight gain, decreased libido, dryness of the mouth, deafness, anorexia, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Jaundice, xanthopsia, paresthesia, photosensitization and necrotizing angiitis are possible.
Average Dosage: One tablet daily with breakfast.
Availability: Pink, single-scored tablets in bottles of 100 and 1000.
(B)46-600-C
For details, please see complete prescribing information.

Geigy Pharmaceuticals
Division of
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Ardsley, New York 10502

RE-6392

INFANT MORTALITY RISES

(Continued from Page 781)

our state and our nation, ourselves and our God. The faddists will take it from there.

Statistics, properly chosen, will serve either side of any opinion.

In the Middle Ages, a child's chances of survival to the age of 10 were fifty-fifty. By the turn of the 20th century, those chances had improved to the point where insurance companies willing to take long odds might have survived, writing infant policies for those able to afford them. Only 20 to 25 per cent of all babies in the world would die within their first 12 months of life.

"Today," says an encyclopedia published 20 years ago, "the death rate of newborn babies (in this country) has dropped to about 4 per cent, a most remarkable achievement for medicine."

With bang-bang precision have come two sets of statistics in recent days that fence us in with enough questions-marks to do us for a time.

First, Victor Fuchs, quoted above, and then the report of Dr. George Cassady, associate professor and director of the Newborn Division and Newborn Nurseries, University of Alabama Hospitals and Clinics, published in the Journal of the Medical Association, in which he said that an infant born in the State of Alabama "has less chance for survival than one born in any of the other states . . . or in Russia, Japan, France and a number of other nations."

All of which puts us at the bottom of the roll call of states—and the United States high on the world's infant mortality standings. Neither is a record to be proud of.

It all goes to show that money won't buy everything—on a seller's market. Nor will yesterday's medium of exchange purchase much today.



THE BRADLEY CENTER

An all new homelike psychiatric residence located on a lovely five-acre tract inside the city, providing a comprehensive range of services, including inpatient (28 beds), day care, and outpatient treatment. The therapeutic setting is an open community one with no provisions for locked wards. Each patient participates in an intensive treatment program consisting of individual pyschotherapy, group psychotherapy, topical small group discussions, occupational therapy and recreational therapy, and other group activities in the Center as well as in the community, depending on individual interests and needs. Drugs are used when appropriate.

Any individual may be admitted who, in the opinion of the staff, might benefit from the services provided in this particular setting. This can best be determined by a preadmission consultation with the person and a responsible member of his family.

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Medical Director

Maj. Gen.(Ret.) Howard Snyder
Administrator

THE BRADLEY CENTER, INC.
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Columbus, Georgia 31901
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What Are The Answers To Spiraling Health Costs?

The spiraling cost of health is of growing concern to the entire medical profession. The fact is reflected in almost every issue of every medical journal and newspaper in the nation.

The dying Democratic administration of the Department of Health, Education, and Welfare predicted continued increases in health care costs, while retiring Secretary Wilbur Cohen threatened physicians that "if they don't hold the line on costs, the government may take action."

The American Hospital Association has said that hospital costs will continue to rise.

The American Medical Association has urged physicians to work to hold down health care costs.

The Medical Society of the State of New York and the state's seven Blue Shield Plans have launched an in-depth study of medical fees, covering all phases of it, including general practice and specialties. The study will take a year and cost $100,000.

Federal outlays for health care will rise to an estimated $18.3 billion next fiscal year, a fourfold increase in five years. And the total will represent some 30 per cent of all health spending in this country.

Gov. Nelson Rockefeller warns of an average $100 a day hospital rate in New York by next year, renewing a plea for a compulsory health insurance program.

The medical profession is fully alert to the fact, not only are spiraling costs of medical services getting completely out of hand, but that far more than its proportionate share of responsibility is being charged directly to the medical profession.

The simple laws of supply and demand continue operative in our case as in any other. The totals of graduate doctors are falling farther behind the exploding population totals every year. Advances in the science of medicine demand more and more time in the continuing education of the American doctor. Unable to keep pace with every facet of it, he is being forced to specialize. The cost of staying in the profession is spiraling upward, and his fees must keep pace with it.

The results can be catastrophic. As Dr. Dwight L. Wilbur, President of AMA, has pointed out, health cost "is wrapped up in the strongest emotions of man. . . The sick person, or the parent of a sick child, is worried and often distraught when in need of medical help. All fears and resentments are magnified. Then, when the illness is over and mercifully pushed out of mind, the bills come in."

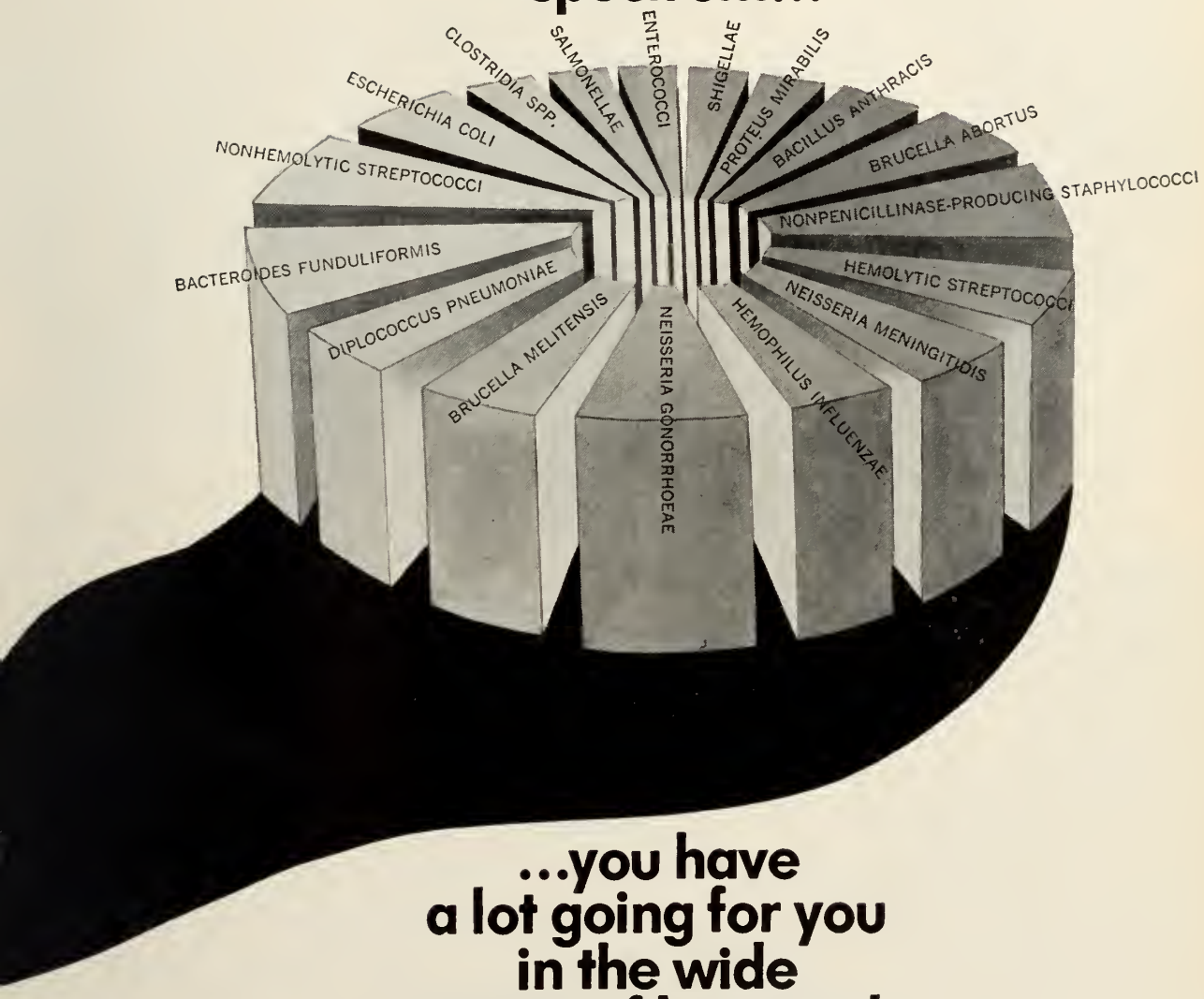
In an article in *Arizona Medicine*, President Wilbur points out that "as physicians we have learned that we treat not just a disease, but the whole patient. We are now learning that as we view the individual, we also must see the group of which he is a part."

And, as the doctor raises his range of vision from the individual to the crowd, from the single hospital bed to the horizon, the public must be made to realize that this means, inevitably, the impersonalization of medical practice—an assembly line for the sick. Personal prescriptions must give way to generic typed medication. Machines will examine the patient and computers will make the diagnosis.

Dr. G. O. Larson, president of the Indiana State Medical Association, sees public relations as a neglected area of medicine. It is public relations, he said, that must map the answers to "power-hungry collectivists in Washington" and everywhere "developing so-called solutions to your problems that can wreck American medicine and American freedoms. . . And . . . if we do not take stock of ourselves, heed these warnings, abandon our apathy and then *act*, American medicine as you and I have known it and loved it is on its way to oblivion."

(Continued on Page 788)

With the broad Polycillin (ampicillin trihydrate) spectrum...



...you have a lot going for you in the wide range of bacterial infections.

PRESCRIBING INFORMATION. For complete information consult Official Package Circular.
Indications: Infections due to susceptible strains of Gram-negative bacteria (including Shigellae, *S. typhosa* and other Salmonellae, *E. coli, H. influenzae, P. mirabilis, N. gonorrhoeae* and *N. meningitidis*) and Gram-positive bacteria (including streptococci, pneumococci and nonpenicillinase-producing staphylococci).
Contraindications: A history of allergic reactions to penicillins or cephalosporins and infections due to penicillinase-producing organisms.
Precautions. Typical penicillin-allergic reactions may occur, especially in hypersensitive patients. Mycotic or bacterial superinfections may occur. Experience in newborn and premature infants is limited and caution should be used in treatment, with frequent organ function evaluations. Safety for use in pregnancy is not established. In gonorrheal therapy, serologic tests for syphilis should be performed initially and monthly for 4 months. Assess renal, hepatic and hematopoietic function intermittently during long-term therapy.
Adverse Reactions: Skin rash, pruritus, urticaria, nausea, vomiting, diarrhea and anaphylactic reactions. Mild transient elevations of SGOT or SGPT have been noted. Black tongue has been noted in some patients receiving the Chewable Tablets.
Usual Dosage: Adults—250 or 500 mg. q. 6 h. (according to infection site and offending organisms). Children—50-100 mg./Kg./day in 3 to 4 divided doses (depending on infection site and offending organisms). Bacterial meningitis —150-200 mg./Kg./day in 6 to 8 divided doses. Children weighing more than 20 Kg. should be given an adult dose when prescribing orally. In parenteral administration, children weighing more than 40 Kg. should be given an adult dose. Beta-hemolytic streptococcal infections should be treated for at least 10 days.
Supplied: Capsules—250 mg. in bottles of 24 and 100. 500 mg. in bottles of 16 and 100. For Oral Suspension—125 mg./5 ml. in 60, 80 and 150 ml. bottles. 250 mg./5 ml. in 80 and 150 ml. bottles. Chewable Tablets—125 mg. in bottles of 40. Injectable—for I.M./I.V. use—vials of 125 mg., 250 mg., 500 mg., and 1 Gm. Pediatric Drops—100 mg./ml. in 20 ml. bottles.
11-1/2/69 **A.H.F.S. Category 8:12.16**

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What Many Patients Need Is A Confidant, Doctor Decides

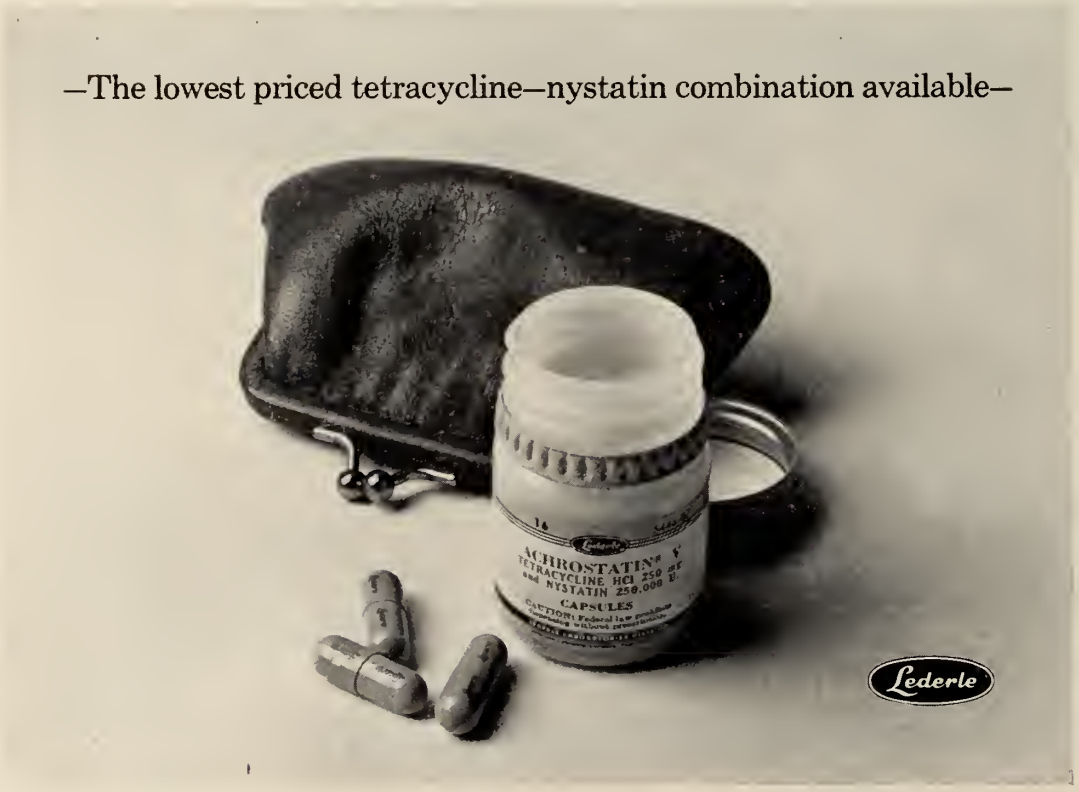
"When I am well I want a general practitioner and when I am sick I want the best specialist," Dr. Arthur P. Richardson, dean of Emory's School of Medicine, told the third annual symposium of the National Pharmaceutical Council, quoting from a popular cliche. He explained it by saying that "maybe the principal reason the public wants more family physicians or general practitioners is the tendency, in most cases, for this type of physician to be willing to spend time with a patient in talking over problems and giving advice."

Confronted by a mounting shortage of health teams—Nixon put the need at 60,000 doctors, 70,000 nurses and 600,000 paramedical personnel—Dr. Richardson suggested that a highly informed public is necessary for better use of physician talent, and wondered if "a health counsellor might fill this need for a patient's confidant. Such a person would not necessarily be an M. D. A pharmacist might perform this function. The health counsellor would require special training in a variety of disciplines not characteristic of any of the current health care team members. His training would be complex and would involve administration and the ability to deal with people."

At the same meeting, Dr. James B. Donaldson, associate dean of Temple University Medical School, complained that "the medical profession usually opposes new ideas but does not propose any new ones." His remarks were aimed at the hospitals especially, commenting that "the over-use and abuse of the hospital emergency department" was complicated by "the over-use and abuse of the hospital emergency department in which 30 to 40 per cent of the patients were of a non-emergency nature."

(Continued on Page 795)

—The lowest priced tetracycline—nystatin combination available—



A once-popular treatment for back pains was to have the seventh son of a seventh son stand or walk on the patient's back.





The pain of earache was allegedly relieved by holding a hot roasted onion to the ear.

For headache, a sovereign remedy was to wear a snakeskin round one's head.



A realistic approach to pain relief



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Compound with Codeine Phosphate gr. 1/2 No. 3

Each tablet contains:
Codeine Phosphate gr. 1/2 (Warning—May be habit forming), Phenacetin gr. 2 1/2, Aspirin gr. 3 1/2, Caffeine gr. 1/2.

keeps the promise of pain relief

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Preludin®
phenmetrazine hydrochloride

Preludin is indicated only as an anorexigenic agent in the treatment of obesity. It may be used in simple obesity and in obesity complicated by diabetes, moderate hypertension (see Precautions), or pregnancy (see Warning). *Contraindications:* Severe coronary artery disease, hyperthyroidism, severe hypertension, nervous instability, and agitated prepsychotic states. Do not use with other CNS stimulants, including MAO inhibitors. *Warning:* Do not use during the first trimester of pregnancy unless potential benefits outweigh possible risks. There have been clinical reports of congenital malformation, but causal relationship has not been proved. Animal teratogenic studies have been inconclusive. *Precautions:* Use with caution in moderate hypertension and cardiac decompensation. Cases involving abuse of or dependence on phenmetrazine hydrochloride have been reported. In general, these cases were characterized by excessive consumption of the drug for its central stimulant effect, and have resulted in a psychotic illness manifested by restlessness, mood or behavior changes, hallucinations or delusions. Do not exceed recommended dosage. *Adverse Reactions:* Dryness or unpleasant taste in the mouth, urticaria, overstimulation, insomnia, urinary frequency or nocturia, dizziness, nausea, or headache. *Dosage:* One 25 mg. tablet b.i.d. or t.i.d. Or one 75 mg. Endurets tablet a day, taken by midmorning. *Availability:* Pink, square, scored tablets of 25 mg. for b.i.d. or t.i.d. administration, in bottles of 100 and 1000. Pink, round Endurets® prolonged-action tablets of 75 mg. for once-a-day administration, in bottles of 100 and 1000. (B) R3-46-560-B

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For complete details, please see full prescribing information.

Geigy Pharmaceuticals
Division of
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Ardsley, New York 10502

Preludin® phenmetrazine hydrochloride

Endurets® prolonged-action tablets



They run a good chance of losing weight.

Exercise and Preludin run together in helping patients to lose weight.

Preludin often puts a natural curb on appetite and frequently promotes a sense of well-being. By boosting a dieter's spirit, Preludin may help patients get the exercise you may prescribe.

One Endurets tablet taken between breakfast and midmorning usually provides daylong and early-evening suppression of appetite.

Mild ulcerative colitis may be triggered here...



In mild ulcerative colitis, a number of factors can precipitate an attack: for instance, dietary indiscretion, such as eating raw foods, or emotional overreaction, such as that aroused by financial difficulties. No matter what causes the patient's sensitive colon to "act up," he soon suffers from acute discomfort...and often, from anxiety and apprehension as well. Such patients frequently respond well to adjunctive dual-action Librax® therapy.

Librax combines, in a single convenient capsule, the well-known antianxiety effect of Librium® (chlordiazepoxide HCl) and the dependable anticholinergic /antispasmodic effect of Quarzan® (clidinium Br). Therefore, as Librax helps to relieve the patient's excessive anxiety and reduce his overreaction to stress, it also, at the same time, helps to control hypersecretion and hypermotility, thus relieving spasm and abdominal discomfort.

With Librax, the dosage schedule is simple: 1 or 2 capsules, t.i.d. or q.i.d., will in most cases bring the patient significant relief of both the emotional and physical elements that contribute to his psychovisceral disorder.

Before prescribing, please consult complete product information, a summary of which follows.

INDICATIONS: Indicated as adjunctive therapy to control emotional and somatic factors in gastrointestinal disorders.

CONTRAINDICATIONS: Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide HCl and/or clidinium bromide.

WARNINGS: Caution patients about possible combined effects with alcohol and other C depressants. As with all CNS-acting drugs, c tion patients against hazardous occupations quiring complete mental alertness (*e.g.*, operat machinery, driving). Though physical and p chological dependence have rarely been repor on recommended doses, use caution in ministering Librium (chlordiazepoxide hyd chloride) to known addiction-prone individu or those who might increase dosage; withdra symptoms (including convulsions), follow discontinuation of the drug and similar to th seen with barbiturates, have been reported. U of any drug in pregnancy, lactation, or in won of childbearing age requires that its poten benefits be weighed against its possible hazar As with all anticholinergic drugs, an inhibit effect on lactation may occur.

PRECAUTIONS: In elderly and debilitat limit dosage to smallest effective amount to p clude development of ataxia, oversedation confusion (not more than two capsules per initially; increase gradually as needed and to

or here.



ed). Though generally not recommended, if ombination therapy with other psychotropics eems indicated, carefully consider individual harmacologic effects, particularly in use of po-ntiating drugs such as MAO inhibitors and henothiazines. Observe usual precautions in resence of impaired renal or hepatic function. aradoxical reactions (*e.g.*, excitement, stimula-on and acute rage) have been reported in psy-hiatric patients. Employ usual precautions in eatment of anxiety states with evidence of im-ending depression; suicidal tendencies may be resent and protective measures necessary. Vari-ble effects on blood coagulation have been eported very rarely in patients receiving the rug and oral anticoagulants; causal relation-hip has not been established clinically.

ADVERSE REACTIONS: No side effects or anifestations not seen with either compound lone have been reported with Librax. When hlordiazepoxide hydrochloride is used alone, rowsiness, ataxia and confusion may occur, specially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver-function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diet.

two good reasons for prescribing LIBRAX®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

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Claim the rewards of sparing your patients the tubes and tribulations of unpleasant enemas.

Compared to enemas, Dulcolax suppositories are a gentler and simpler way to empty the bowel. Gone are the tubing, the "accidents", and the bruised egos. Just one suppository, inserted against the bowel wall, usually brings about an evacuation within 15 minutes to an hour.

In the hospital, order Dulcolax for constipation or bowel cleansing. Your patients will often prefer it to embarrassing enemas. And you can be sure nurses will appreciate the saving in time and effort.

Dulcolax tablets taken at night usually result in a bowel movement the following morning. A combination of tablets at night and a suppository the next morning generally cleans the bowel thoroughly in preparation for surgery or special procedures. Keep in mind, however, that the drug is contraindicated in the acute surgical abdomen.

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DU-6

GUEST EDITORIAL

The Trouble With Smoking Is Starting*

During the past month, book matches have been distributed by this publication throughout the community, state, and nation carrying the message of the title of this Editorial. The Trouble With Smoking Is Starting. The original morbid skull and crossbone seal of the Worcester District Medical Society prominently appears on the match book cover. It serves as a crisp reminder of the indisputable hazards from smoking and is especially geared for the teenager. The glamorous image of the virile young man and sophisticated woman is what seduces the teenager into smoking. After he has begun, the adhesive force of tobacco dependence gains increasing strength. The trouble with smoking is starting.

The medical profession is the most effective leader in the anti-tobacco campaign. However, at times emphasis on the goal has obscured complete insight into the problem. The intelligent adult who smokes appreciates the health hazards. He, and his family, are beset by great feelings of guilt and frustration upon viewing the current anti-smoking television commercials. Furthermore, it is most inconsiderate for hospitals to remove tobacco dispensing machines. Visitors to a hospital are not touring a museum, but rather commonly involved in an emotional strain associated with the illness of a loved one. If the visitor happens to be a smoker then tobacco should be available if desired. It is hardly the time or setting to give up the habit. It is suggested that all hospitals have posters placed in their tobacco dispensing machines which read like the one composed by Doctor Robert Switzer of the Menninger Clinic: "Members of our staff recognize that cigarette smoking is an extreme health hazard. The use of this machine is not recommended. It is placed here only temporarily until such time that public opinion, based on understanding and acceptance of available facts about the harm done by habitual use of cigarettes, demands removal."

In conclusion, the trouble with smoking is starting. We would be most happy to send our match book to anyone upon request.

*From the Worcester Medical News, official organ of the Worcester (Mass.) District Medical Society. The address: 57 Cedar Street, Worcester, Mass., 01609.

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PHYSICIAN PLACEMENT SERVICE IN ALABAMA

The Physician Placement Service of the Medical Association of the State of Alabama is designed to assist both physicians and communities. MASA members having knowledge of practice opportunities or wishing to relocate their own practices are urged to communicate with the Placement Service. For further information: write Mr. Emmett Wyatt, Executive Assistant, Medical Association of the State of Alabama, 19 South Jackson Street, Montgomery, Alabama 36104, or Telephone 263-6441.

Locations Wanted

General Practice—

Age 44, Medical College of Alabama, 1967, seeking associate practice in town of 12,000 plus population in central or south Alabama. LW-1

Age 56, Georgetown University 1938; seeking solo, group or associate practice, with general surgery. LW-2

Age 52; University of Chicago 1950; seeking group, industrial, institutional or student health position. LW-3

Age 31, Western Reserve, 1964; seeking group, associate or institutional practice. LW-4

Age 38; University of Oklahoma, 1955; seeking associate, institutional or industrial practice; in town of 10,000 plus population; interest in surgery. LW-5

Age 28; Medical College of Alabama 1966; seeking practice in town of less than 14,000 population to fulfill scholarship requirements. Available 1968. LW-6

Age 28; University of Tennessee, 1965; available November 1968. LW-7

Age 27, Medical College of South Carolina, 1966; seeking location in Gadsden area or in southern part of state in town of 5-7,000 population; available July 1, 1971. LW-7/1

Age 38; Medical College of Alabama, 1957; seeking location in south Alabama. LW-7/2

Internal Medicine—

Age 36, Medical College of Alabama, 1963; seeking solo, group, or associate practice. LW-8

Age 34; University of Mississippi 1960; Board eligible; seeking location in southern section of Alabama in city of 15,000 plus population. LW-9

University of Mississippi 1963; seeking group practice in city of 20,000-40,000 population. LW-10

Age 34; Hahnemann Medical College 1959; Board eligible, National Board; seeking solo, group, or associate practice. Available immediately. LW-11

Age 35; University of Tennessee 1958; Board certified; seeking group, industrial or institutional practice. LW-12

Age 37, Duke University, 1956; Board certified, seeking group, associate, or institutional practice. LW-13

Neurology—

Age 32, Medical College of Georgia, 1964, seeking assistant or associate, or institutional practice. LW-14

Age 31; Harvard 1962; Board eligible; National Board; seeking solo, group or associate practice. Available July 1969. LW-15

Age 30; Medical College of Alabama 1962; Board eligible; National Board; seeking solo, group, associate or institutional practice. Available January 1969. LW-16

Age 29, Indiana Univ., 1964; Board eligible; seeking assistant or associate practice in city of over 100,000 population; available July 1, 1969. LW-17/1

Obstetrics-Gynecology—

Age 35, Vanderbilt University, 1950. Board eligible. LW-18

Age 49, University of Nebraska, 1943; Board certified, seeking group or institutional practice. LW-19

Age 34, Medical College of Virginia, 1961, Board eligible, seeking group or associate practice. LW-20

Age 33; University of Illinois, 1964; seeking associate practice. LW-21

Ophthalmology—

Age 33; St. Louis University, 1962; seeking solo, or associate practice; available July 1, 1969. LW-21/1

Radiology—

Age 39; Louisiana State University 1954; seeking solo or associate practice. Available July 1969. LW-22

Age 31; S. U. N. Y. College of Medicine, 1961; Board eligible; seeking solo, group, or associate practice. LW-23

Age 41; Cornell Univ. Medical School, 1953; Board certified; seeking group, or associate practice. Available immediately. LW-24

Age 51; Univ. of Texas Med. Branch, 1942; Board certified; seeking solo, group, or associate practice. LW-25

Surgery—

Age 30; Duke University School of Medicine, 1964; seeking location in larger cities. LW-26

Age 33; University of Missouri, 1961; seeking group or associate practice. Available January 1969. LW-27

Age 38; Emory University, 1956; Board eligible, seeking group, associate, or institutional practice. LW-28

Age 37; Faculty of Medicine, Manitoba, 1957; Board certified; seeking associate or institutional practice. LW-29

Locations Wanted

(Continued)

Age 34; University of Santo Tomas, 1961; Board eligible, seeking group or associate practice. LW-30

Age 35; University of Santo Tomas, 1956; Board eligible, seeking solo, group or industrial or associate or institutional practice. LW-31

Age 31; Medical College of Alabama, 1962; Board eligible; passed National Board; seeking assistant, associate, institutional or group practice in city of over 50,000. Available July 1969. LW-31/1

Urology—

Age 30; Louisiana State University, 1963; Board eligible, seeking associate, or group practice. LW-32

Physicians Wanted

Special Openings—

Specialist in the following fields: Internal Medicine, Pediatrics, Obstetrics-Gynecology and General Practitioners. 58-bed fully accredited general hospital with 91-bed addition recently completed. Modern new office space available. PW-20

Pediatrician, Internist, and ENT specialist to join a well-established group practice in a community of 40,000 in East Alabama. The community has a 125-bed accredited hospital, 32-bed extended care facility. Good transportation on interstate with quick access to metropolitan area. Will pay travel expense for interview. PW-20-1

Opportunity for general practitioners or internists for institutional practice at TB Sanatorium in North Alabama. PW-21

Opportunity for physician interested in joining a progressive public health tuberculosis control program working in Birmingham, Jefferson County. Provide outpatient medical services and some administrative duties. Fringe benefits and salary open. PW-22

Student Health—

New 75-bed facility to be occupied in late 1968. Present staff of seven full-time physicians. Salary negotiable. Appointments are full time with regular University benefits. PW-23

Full time salaried position of assistant director on staff of four 65-bed well equipped infirmary with adequate office space. Excellent laboratory and X-ray facilities. Liberal fringe benefits. PW-24

Obstetrician-Gynecologist—

Excellent opportunity for a trained Ob-Gyn man who would join a three-man partnership practice in city of 30,000 population located in southwest Alabama. Salary is proposed for the first 12 months, a limited partnership to begin at the end of twelve months, and full partnership to begin at the end of 24 months. PW-25

General Practitioners—

Opportunity in town of 4,000 population in trade area of 50,000 population, located within 100 miles of two metropolitan areas in south Alabama. Industrial and farming area. 44-bed hospital. Office space and equipment available in new building with another physician. Several churches, schools, and service clubs. PW-1

For community of 1,500 population located in south Alabama near city of 12,000 population. Hospitals located within 25 miles. Office space and equipment available. Farming, cattle and textile industries in the area. Several churches and school. Civic clubs and golf courses. PW-1-1

For town of 10,000 population in county of 40,000 population located in scenic mountainous section of Northeast Alabama. Office space and equipment available. Hill-Burton hospital-nursing home. Expanding industries in top agricultural area. PW-1-2

For community of 2,000 population, plus large trade area, located in Southeast Alabama. Modern clinic, fully equipped. PW-1-3

Opportunity in port town of 1,000 plus population in population center of 10,000 located in Southeast Alabama. Clinic available. Hospital located less than 20 miles away. Recreational advantages for water sports. Expanding industrial and farming area. Churches and schools. PW-1-4

For town of approximately 1,000 population in Northwest Alabama, near Tennessee Valley waterways. New 15-bed clinic available. Centrally located near metropolitan areas. Extensive industrial developments. PW-1-5

For town of 12,500 population in trade area of 50,000 located in South Alabama. Nearest large city with population of 145,000 is 80 miles away. Two hospitals with 140 beds. Numerous small industries. Several churches and schools. Recreational activities include water sports and golf course. PW-1-6

Opportunity for group practice in town of 10,000 population in north Alabama. PW-2

Physician wanted to join 39 year old Medical College of Alabama graduate in a well established general practice in West Central Alabama town. Salary initially followed soon by full partnership. PW-3

Opportunity in community of 5,000 population in trade area of 30,000 population located in northeast Alabama where at present time there are only two active full time general practitioners. Modern offices or clinic facilities available. 48-bed accredited hospital and 52-bed skilled nursing home adjoining the hospital. Cities of approximately 75,000 population located within 25 miles distance. Agricultural and expanding industrial area. Numerous churches and schools. Country club and golf course being developed and water sports and outdoor activities offer recreational advantages. PW-4

(Continued on Page 798)

Physicians Wanted

(Continued from Page 797)

For town of 2,000 population in trade area of 5,000 located in South Alabama, within 24 miles of large city of 37,000 population. Nearest hospital (50 beds) is 12 miles away. One physician presently in practice in town. Office space available. Military base, farming, and small industries afford resources. Numerous civic clubs, two schools, and five churches. PW-5

For town of 4,500 population in trade area of 10,000 to 15,000 with annual payroll of 4½ million dollars, located in north central Alabama. Within 75 and 85 miles respectively of two metropolitan areas with combined population of 2 million. Hospital privileges available in modern 30-bed hospital. A modern 40-bed extended care facility adjoins hospital. Excellent churches, schools and shopping areas. In the center of the best hunting, fishing and recreational area in the state. PW-6

Physician wanted to join well established partnership in Northwest Alabama city of 15,000 population. Two accredited hospitals, junior college, schools, churches, recreational activities. No obstetrics or surgery. New office building. PW-7

For city of approximately 15,000 population in north Alabama, with trade area of approximately 45,000 population. Hospital with over 100 beds, and expansion planned for next year. Nursing homes in the area. Industrial growth and agricultural region. Several churches and schools. Golf course, civic and fraternal organizations. PW-8

For partnership practice in clinic in town of 2,000 population in area of 10,000 population located in north-central Alabama. 40-bed hospital. PW-9

For assistant or associate in clinic located in town of 10,000 population located in northeast Alabama. 65-bed Hill-Burton hospital. PW-10

For associate practice in city of 6,000 population in area of over 10,000 population located in East-central Alabama. PW-11

For solo practice in county clinic located in East-central Alabama. Office, equipment and housing available. 70-bed Hill-Burton Hospital and 22-bed nursing home. PW-12

For town in southwest Alabama, approximately 1,000 population in trade area of approximately 5,000 population, within 60 miles of large city of 35,000. Nearest hospital is located 18 miles away. Arrangements available for office space. Small industries and agriculture. Civic clubs and golf course nearby. Churches and school. PW-13

For town of approximately 1,000 population in population center of 10,000 located in Southwest Alabama within 90 miles of the Gulf coast. City owned clinic is offered rent free and fully equipped. Hospitals are located in two nearby towns within 25 miles. This is principally an agricultural region, but there are military installations nearby. Numerous civic clubs, community concert series, and a country club offer recreational activities. PW-14

For town of 1,000 plus population in west-central Alabama in trade area of 20,000. Clinic available. Nearest city of approximately 70,000 population is located a distance of 17 miles. Farming, cattle, timber, and manufacturing plants are principal resources of the area. Churches, schools, and recreational advantages. PW-15

Opportunity for general practitioner to join a five-man group, practicing as a partnership. Each man in the group is either specialized or semi-specialized. The practice is physically located within a 70-bed hospital. Willing to pay qualified person $36,000 for the first year, with possible partnership status in one year. Would consider a physician for locum tenens for three to six months at $2,000 per month. PW-16

For town of 3,600 population in trade area of 5,000-7,000 within 100 miles of two large cities and the Gulf Coast. 50-bed hospital located in the town. Office space available. Agricultural and expanding industrial area. Several churches and two schools. Recreational activities in the town as well as nearby—golf course, hunting and fishing. PW-17

Unusual opportunity for two general practitioners with military obligations satisfied at a modern fifty bed facility located 15 minutes drive from largest metropolitan center in north-central Alabama. Construction of a new two-story office building is scheduled to begin soon. PW-18

Opportunity in city of 5,000 population located in Northeast Alabama in trade area of approximately 10,000 population. Office space available. One physician died recently. Hospital and nursing home in the city. PW-19

Construction and Recruitment Taking Place

Grading of the site for the Lurleen B. Wallace Mental Retardation Hospital, Decatur, has been substantially slowed due to inclement weather during December and January. However, the design and drafting for this facility is virtually complete and second stage drawings submitted to all parties concerned for the Administration, Diagnostic and Evaluation Building, and the Food Service Building. First stage submittals have been made for the Training and Activity Center, the Vocational Training Center, and the Cottages. Dry and sunny skies—soon expected—should put this facility right back on schedule. Meanwhile, the academic building at Partlow is in the final stages of completion and should soon be ready for use.

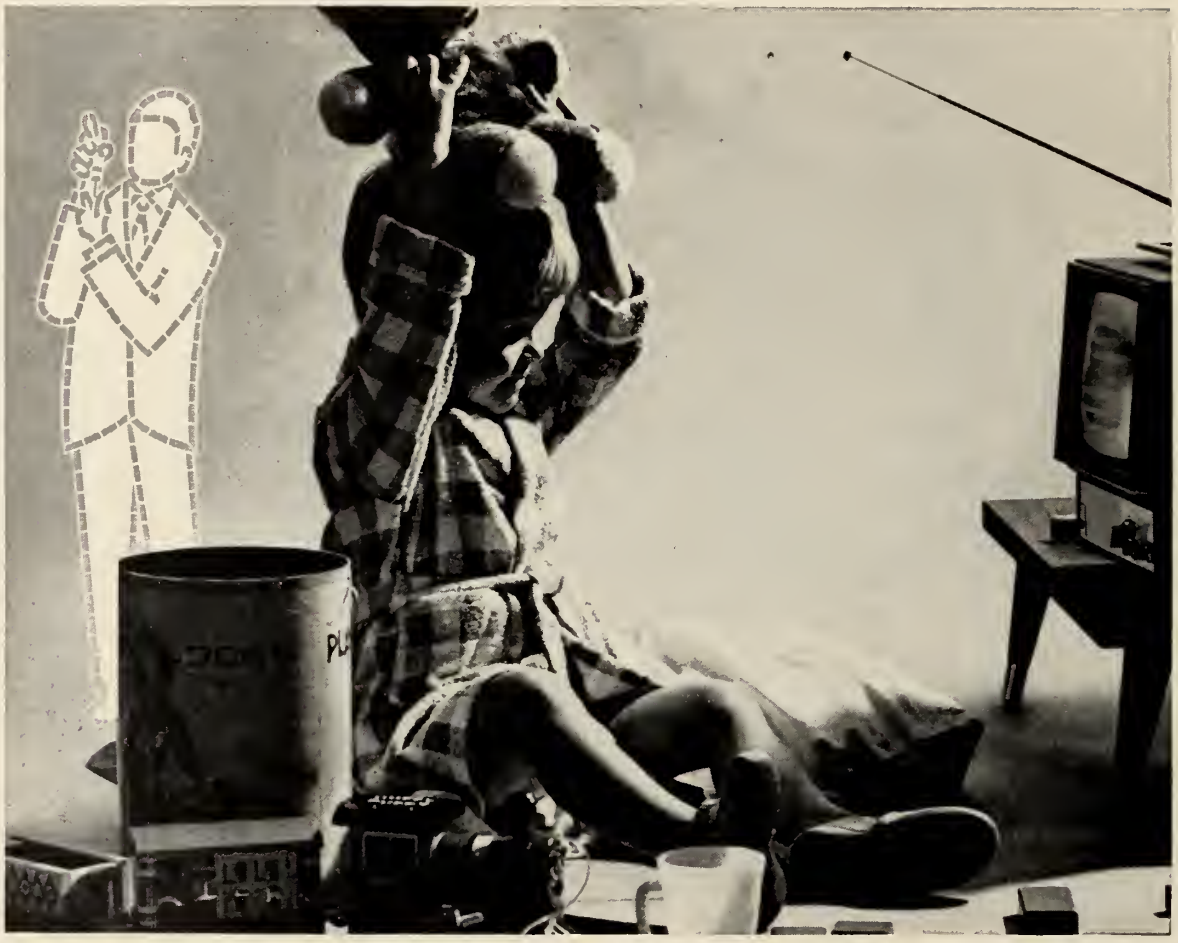
Painting contracts at Bryce and Searcy Hospitals are nearing completion, and the architects have submitted renovation plans through Phase IV of the three existing hospitals. Estimated costs of this renovation is approximately one and one half million dollars. The Board of Trustees of the Department recently approved an additional $76,733 allocation—making a total of $176,733—for The Mobile General Hospital for construction of a fifty bed psychiatric unit which is part of the Mobile Comprehensive Mental Health Center. Approximately $60,000 has been allocated to the $240,000 Psychiatric Day Care Unit of the University Hospital in Birmingham. The Ozark Mental Retardation Day Care Center has received an allocation of $86,000 as the Department's share of the $429,000 facility. The Retarded Children's School and Day Care Center in Montgomery—a $166,000 facility—has received an allocation of $33,200. The Muscle Shoals Mental Health Center construction is on schedule with expected occupancy in October of 1969. Dr. R. Edwin Baggs, Clinical Psychologist and Director of the Center arrived in Florence in December from Illinois where he has chalked up an impressive record with the Department of Mental Health.

Dr. Stonewall B. Stickney, Department Director, describes the program as "moving and moving with accomplishment." He has announced to the Board of Trustees several appointments already in effect and to take effect during the spring of 1969. Erwin Stasek, Ph. D., Director of Youth Services for Dade County, Florida—Miami—has been appointed Director of Children's Services. Dr. Stasek will begin his duties of program planning for children in public schools, day care centers, retardation centers, mental health clinics, and the three institutions after his arrival March 1. Dr. Ben Allen, Associate Professor in Special Education at the University of Georgia has been appointed Director of Mental Retardation and is expected to be on the job in April. Dr. Adolph Blakeney at Bryce has been given a central staff appointment as Director of Staff Development and Patient Education at all three institutions. Dr. Bernard Rovati has been appointed assistant to Dr. Rowe at Searcy with additional responsibility of helping with training and licensure preparation of the unlicensed physicians. Two Registered Nurses have also been employed at Searcy to assist Dr. Blakeney in the in-service training program for staff. Dr. John Cranton, a young psychiatrist in the Mobile area is now consulting at Searcy and assisting with staff development.

Joe Coon, active for several years in Community Services, has been appointed Acting Director of that Division.

John Yeatts of South Carolina and Virginia has been appointed Director of Information Service and has been working since mid December.

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Warnings: In rare instances, penicillin may cause acute anaphylaxis which may prove fatal unless promptly controlled. This type of reaction appears more frequently in patients with a history of sensitivity reactions to penicillin or with bronchial asthma or other allergies. Resuscitative drugs should be readily available. These include epinephrine and pressor drugs (as well as oxygen for inhalation) for immediate allergic manifestations and antihistamines and corticosteroids for delayed effects.

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In prolonged therapy with penicillin, and particularly with high parenteral dosage schedules, frequent evaluation of the renal and hematopoietic systems is recommended.

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Administration and Dosage: Usual dosage range, 125 mg. (200,000 units) three times a day to 500 mg. (800,000 units) every four hours. For infants, 50 mg. per Kg. per day divided into three doses.

See package literature for detailed dosage instructions for prophylaxis of streptococcus infections, surgery, gonorrhea, and severe infections.

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X-Ray Evaluation Of Duodenal Trauma In Children

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Blunt trauma to the epigastrium affecting the duodenum gives rise to two major lesions: Intramural Hematoma and Rupture. The purpose of this paper is to emphasize the necessity of routine X-ray evaluation by reporting our experience with two cases of each.

In 1964, Burtelesen and Suhr[1] referred 30 cases of intramural hematoma of the duodenum and Cook and Myer[2] reviewed 48 cases of duodenal rupture. Both articles emphasized that these lesions are "difficult to handle and particularly dangerous to mishandle." The mortality rate has been reported[2] as high as 33 per cent with conservative therapy as compared with an operative mortality of five per cent. Complications run as high as 70 per cent.

Intramural Hematoma

The patient with intramural hematoma gives a history of blunt trauma to the epigastrium. It is important to emphasize that this might appear to be minor in nature. Symptoms may be immediate and usually occur in a few hours to a few days. Our emphasis here is on the traumatic intramural hematomas; however, spontaneous ones have occurred and have been reported in association with pancreatitis, liver disease and anticoagulant therapy. The duodenum is particularly susceptible to trauma due to its short mesentery and its position over the vertebral bodies. Remarkably high intraluminal pressures can develop because of the closed loop effect created by the pyloric valve and the acute angulation of the duodenum at the ligament of Treitz. Moore and Earlingson[5] emphasized the peculiarity of the ramifications of the intramural arteries in the muscularis of the duodenum which makes them particularly susceptible to tearing.

The patient's complaints are usually those of nausea and epigastric pain radiating to the back. The signs are of mechanical obstruction with vomiting and hematemesis. Examination will reveal epigastric tenderness and possibly a mass. Laboratory studies may show minimal to marked changes secondary to hemorrhage, biliary obstruction and pancreatic trauma. X-ray evaluation is directed at demonstrating the hemorrhage which may be minimal to marked. The obstruction may be complete or partial as the extravasation may be subserosal intramuscular and/or submucosal. Extravasations have been reported to have extended into the hepatoduodenal ligament with common bile duct and pancreatic duct obstruction. Since these injuries usually involve multiple organ systems it is particularly important that the entire abdomen, the urinary tract as well as the upper

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gastrointestinal tract be evaluated. This also gives one an opportunity to see the transverse processes in the lumbar region. A chest film should always be obtained to check the rib cage, rule out aspiration pneumonitis and as a base line in case of postoperative complications. The X-ray studies recommended with the order of their performance are as follows:

1. PA and lateral upright films of the chest.
2. Supine, erect or left lateral decubitus films of the abdomen.
3. Intravenous urogram.
4. Opaque media studies of the upper gastrointestinal tract.

CASE I—L. L.—This 14-year-old colored male was admitted to The Children's Hospital, Birmingham, Alabama, for the first time on June 4, 1965, with a 48-hour-history of nonpenetrating abdominal injury following a fall of only 1-2 feet while climbing on rocks. The patient stated that he struck his epigastrium and there was immediate pain in this area which subsequently subsided. There was also early vomiting which gradually subsided only to recur 36 hours prior to admission and become progressively worse. There was also an elevation of temperature during this time.

Physical examination revealed the patient to be a slender but well developed well nourished colored male of 14 years with a few right upper quadrant superficial abrasions. He was approximately ten per cent dehydrated. The positive findings were limited to the abdomen. There was definite tenderness and guarding on palpation of the right upper quadrant. Bowel sounds were present but weak. There was a suggestion of fullness in the right upper quadrant but this was ill-defined. Rectal examination revealed firm feces and was otherwise negative.

Admission laboratory studies revealed a white blood cell count of 13,000 with 87 per cent polys and 12 per cent lymphs. Hemoglobin was ten grams and hematocrit was 32 per cent. Platelets were adequate. The urine analysis was remarkable in that it was positive for acetone and salicylates. There were 0 to 2 white blood cells per high-powered field and an occasional red blood cell. The CO2 was 26 mM/L and the serum chlorides 100 mEq/L.

X-ray examination of the chest was negative. Scout film of the kidney, ureter and bladder areas revealed lumbar scoliosis with concavity to the right (Fig. I). Intravenous



Fig. I (Case I)—Scout film of the abdomen reveals lumbar scoliosis with concavity to the right.

urogram revealed the pelves, calyces and ureters of both kidneys to be normal. (Fig. II). The following morning an upper gastrointestinal study was done revealing obstruction at the pyloric end of the stomach with compression of the antrum on the greater curvature side by an intramural or extrinsic mass. (Fig. III). The patient was kept on bed rest and given replacement fluids while on nasal suction. On 6-6-65 the child was taken to surgery and under general anesthesia an abdominal exploration was carried out. This revealed a large duodenal hematoma



Fig. II (Case I)—Intravenous urogram reveals the pelves, calyces and ureters of both kidneys to be normal.



Fig. III (Case I)—Upper gastrointestinal study reveals obstruction in the antrum of the stomach with compression of the greater curvature side by the intramural hematoma.

that extended proximally into the stomach and distally to the third portion of the duodenum. A transverse incision of the duodenal wall was adequate to evacuate the hematoma. A gastroenterostomy was carried out for decompression purposes. The patient tolerated the procedure well. The postoperative course was uneventful. Two intramural drains were left in the hematoma site and one was brought out eight hours after surgery. The second drain was removed slowly over an eight-day period. An upper gastrointestinal study on the tenth day after surgery revealed that there was good function of the gastroenterostomy as well as free passage of the contrast media through the duodenum. There was indentation of the medial aspect of the descending duodenum due to residual edema of the wall. The patient was discharged on 6-16-65 without complications. Further check-ups over the past three years' time have shown no evidence of residual difficulties.

CASE II—C. J. C.: This 8-year-old colored male was admitted to The Children's Hospital on the evening of 3-31-68. The mother stated that in the afternoon three days prior to admission the child tripped and fell across railroad tracks, striking his epigastrium. The blow did not seem to be severe and that evening the patient ate his usual meal though he complained of a moderate amount of epigastric pain. He spent a restless night, sleeping off and on, being awakened on occasions by stomach aches. The following morning he began vomiting and continued to do so with abdominal pain and nausea persisting to the time of admission. He was able to retain neither solids nor liquids. Just prior to admission the patient began vomiting blood. There had been no diarrhea.

Physical examination revealed a thin dehydrated Negro male child appearing acutely and chronically ill. The blood pressure was 104/70; pulse 90, and temperature was 100.4 degrees. The skin showed marked loss of turgor and elasticity. The eyeballs were sunken and mucous membranes of the mouth were dry. There was marked tenderness in

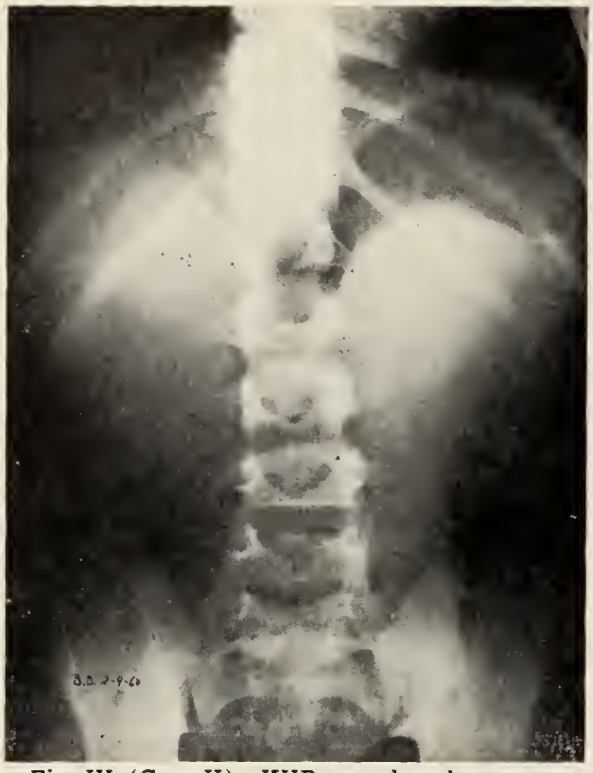


Fig. IV (Case II)—KUB reveals a homogenous mass in the left upper quadrant which displaces the gas-filled stomach cephlad.



Fig. V (Case II)—Intravenous urogram shows the pelves, calyces and ureters of both kidneys to be normal.



Fig. VI (Case II)—Study of the upper gastrointestinal tract shows the mass to displace the stomach anteriorly and superiorly. The opaque media enters the duodenum but the flow was obstructed at the junction of the second and third portions by the intramural hematoma.

the left upper quadrant and epigastrium with muscle guarding. Bowel sounds were absent. A 5-cm. mass was palpable in the left upper quadrant which did not move with respiration.

Laboratory evaluation at the time of admission showed the hemoglobin to be 14.5 grams. Hematocrit 40 per cent. Just prior to surgery 4-1-68 the hemoglobin was 11.4 grams and the hematocrit 35 per cent. White blood cells had remained constant at 12,000. There was a normal differential. The urine study was negative.

X-ray examination of the chest was negative. The erect and supine films of the abdomen revealed a homogenous shadow of increased density in the left upper quadrant which displaced the stomach superiorly. (Fig. IV). The abdomen was essentially devoid of

gas. There was blurring of the left renal outline.

Intravenous urogram was normal. (Fig. V) Fluoroscopic and radiographic examinations of the upper gastrointestinal tract revealed a negative esophagus. The stomach was displaced superiorly by the previously mentioned homogenous shadow in the left upper quadrant. (Fig. VI). The opaque media freely entered the duodenum, revealing obstruction in the horizontal portion. The radiographic impression was hematoma of the duodenal wall with obstruction.

The patient was explored at 11:20 a. m. on 4-1-68, after proper preoperative care. Exploration of the abdomen revealed a palpable hematoma in the epigastrium which extended into the transverse portion of the duodenum and around past the ligament of Treitz into the proximal jejunum. The hematoma was evacuated by piercing the serosal layer just below the ligament of Treitz. The liquid portion of the hematoma was removed by suction and the clots in the muscularis by saline irrigation. A drain was placed just inferior to the duodenum and jejunum without touching either and brought through a separate stab wound in the abdomen. The postoperative period was uneventful. On 4-9-68 re-ray of the upper gastrointestinal tract was normal.

Rupture of the Duodenum

Rupture of the duodenum is usually retroperitoneal but can be intra-abdominal. Cook and Myers[3] in their review of 48 cases found free air in the abdominal cavity in only three. There was blurring of the psoas shadow or a retroperitoneal gas pattern, such as perirenal air in 17 additional cases, leaving 28 cases in which there was no free air. A fracture of a transverse process occurred in three. It was noted that duodenal rupture usually gave rise to more immediate signs and symptoms than it did intramural hemorrhage. These patients also gave a history of epigastric trauma and, again, we should emphasize that this may appear to be minor. The chief complaints were usually those of epigastric pain and tenderness at the site of injury. The pain may be mid-line, right lower or upper quadrants. This is usually associated with nausea and vomiting and occasionally bright red blood in the vomitus. Examination reveals epigastric or right-sided tenderness with guarding and may progress to abdominal wall rigidity, acute generalized abdominal tenderness, absent bowel sounds and shock. In the 48 cases[3] mentioned above, there was a 19 per cent mortality rate with 69 per cent of the survivors having complications. Duodenal fistulas and retroperitoneal abscesses accounting for two-thirds of these. Fifteen per cent of the patients having ruptures were either not operated on, or the lesion was not found at laparotomy, and 71 per cent of these patients died. They stated that it was a difficult lesion to handle and a dangerous one to mishandle due to the frequent history of trivial injury, lack of initial symptoms, unsuspecting surgeon, diagnostic delay and failure to locate perforation at the initial laparotomy. The majority of ruptures were due to blows in fights, athletic events, falls or possibly abrupt minor blows to the relaxed abdomen. The damage was usually due to the closed-loop type of mechanical phenomena. The key to diagnosis is suspicion where there is a history of trauma to the epigastrium.

X-ray examinations indicated are identical to those for suspected intramural hemorrhage. X-ray signs on the scout films may be very similar plus the presence of free air. In the absence of free air definite diagnosis is made by injecting an opaque media into the Levine tube and doing a fluoroscopic evaluation of the duodenum. The opaque media study should be eliminated if free air is present in the peritoneal cavity but all other procedures should be carried out as outlined.

CASE III—M. C.—This 3-year-old white male was admitted to The Children's Hospital of Birmingham on 6-10-68 at 10:00 a. m. The parents gave a history of this child having been injured by a fall across a large stone at 6:00 p. m., the previous evening. There were

no particular symptoms at the time although the child did cry considerably. A small superficial abrasion was seen in the right epigastrium. Approximately one hour after injury the child became restless and began a grunting respiration. There was no vomiting. Within an hour and a-half the child was taken to a local hospital where he was seen by a surgeon who found only superficial abrasions and contusion of the right lower chest and epigastrium. A physical examination was done and the child was not thought to be sufficiently injured for hospitalization. No X-ray procedures were carried out. One hour later he was seen by his pediatrician who stated that the abdomen was flat and nontender. The child was active and he agreed that it would be all right to release the child to go home. The mother stated that the child vomited on the way home and several times at home but walked to bed. He was noted to continue to be restless. There was belching followed by vomiting which seemed to give him relief and he would doze off to sleep. At approximately 12:30 a. m. he awoke, asked for water and drank several glassfuls between that time and 3:00 a. m. At 6:00 a. m. he began to vomit blood-tinged material. There were no bowel movements and no urination. The patient was taken back to his local hospital where an X-ray examination of the chest was done as well as flat and upright films of the abdomen. The chest was interpreted as negative and no free air was seen on the abdomen films. The child was in shock, however, and after oxygen had been administered and a cutdown done the child was transferred to The Children's Hospital.

Physical examination at time of admission to The Children's Hospital revealed an extremely ill child in a state of shock. Pulse was 140; respiration 26; blood pressure 88; systolic with a diastolic not recorded. Temperature was 102.8 degrees. Laboratory examination revealed the hematocrit to be 68; hemoglobin 15.3 gm.; white blood cell count 8500; platelets were adequate. The urine was negative. Enthusiastic efforts were made at resuscitation and the patient was taken to



Fig. VII (Case III)—X-ray examination of the chest reveals free air beneath the diaphragm. The lung fields are clear.

the X-ray Department. PA and lateral views of the chest revealed free air beneath the diaphragm. (Fig. VII). The supine and erect films of the abdomen revealed free air beneath the diaphragm and a loss of the right psoas shadow (Fig. VIII). Intravenous urogram (Fig. IX) revealed normal pelves, calyces and ureters. The radiologist's impression was "ruptured hollow viscus."

At the time of surgical exploration a tear in the mesentery was found with contusion of the transverse colon and a small tear in the serosa of the jejunum. Further exploration revealed a 90 per cent tear of the duodenum at the junction of the second and third portions. There was edema of the head of the pancreas. The biliary tract was normal. The right kidney appeared to be negative. A large amount of bile stained fluid was removed from the abdomen and the peritoneal cavity was washed out with copious amounts of saline. The duodenal, jejunal and mesenteric tears were repaired and drains were placed in the right upper quadrant in the vicinity of the repairs. Postoperatively the child did well but within 24 hours began to spike fever. Immediate radiographic studies were not diagnostic other than to say that



Fig. VIII (Case III)—Erect film of the abdomen reveals free air beneath the diaphragm and loss of the psoas shadow on the right.



Fig. IX (Case III)—Intravenous urogram shows both kidneys to be normal.

there were postoperative changes in the right upper quadrant with scoliosis of the lumbar spine. Films taken three days postoperatively, however, revealed small collections of free air in the retroperitoneal area on the right side at the operative site which could have been due either to leakage at the anastomosis or gas-forming organisms. Fluoroscopic and radiographic examinations of the upper gastrointestinal tract showed no evidence of leakage and a diagnosis of retroperitoneal abscess was made. The abscess was explored, drained and catheters put into position for irrigation. The patient was placed on antibiotics. Two days later a catheter was injected with Hypaque to outline the abscess cavity and its ramifications. It appeared to be limited to the flank area. The cavity was then re-explored, freed up and cleaned out. Repeat studies two days later showed the cavity to extend down retroperitoneally into the pelvis. At the time of this writing the patient has no fever and clinically is continuing to improve.

CASE IV—Wm. McE.:—This 15-year-old white male was admitted to The Children's Hospital for the first time on 12-15-67 with a history of having been thrown across a rail on the back of a seat in a bus. The blow was across the epigastrium and gave rise to a diffuse upper abdominal pain which subsequently localized more to the right upper quadrant. There was a component of pain located in the left shoulder and arm. He subsequently vomited on three occasions, bringing up coffee-ground material. At the time of admission he had not voided or had a bowel movement.

Physical examination revealed an alert white male of the given age in acute distress lying on a stretcher in a doubled up position. His color was slightly pale. His initial blood pressure was 140/80; pulse 84 and regular.

Respiratory rate was 22 and shallow. He vomited coffee-ground material during the course of the examination. Lung fields were clear. The heart findings were normal. The abdomen was flat. There was diffuse abdominal guarding with no palpable masses. Generalized abdominal tenderness was elicited with some possible increase in the right upper quadrant. Bowel tones were hypoactive.

Admission laboratory studies revealed an hematocrit of 44 per cent, hemoglobin 15.3 grams and a normal urinalysis. These findings remained constant until the time of surgery.

X-ray examinations consisted of PA and lateral chest, supine and lateral decubitus films of the abdomen, intravenous urogram followed by opaque media study of the upper gastrointestinal tract. X-ray examination of the chest was negative. Scout films of the abdomen revealed a lumbar scoliosis with concavity to the right (Fig. X.). There was partial loss of the right psoas shadow with a homogenous area of increased density in the right upper quadrant. The right renal outline was only partially visualized. Lateral decubitus views showed no definite evidence of free air in the abdominal cavity. There were several small irregular areas of air in the region of the first portion of the duodenum which were suspicious for free air, however. There was no evidence of fractured ribs or transverse processes. Intravenous urogram (Fig. XI.) revealed the pelves, calyces and ureters of both kidneys to be normal. The suspicious air in the right upper quadrant was again apparent indicating a retroperitoneal escape of air from the bowel. Fluoroscopic and radiographic examinations of the upper gastrointestinal tract revealed a negative stomach. (Fig. XII.). There was perforation of the duodenum with extravasation of

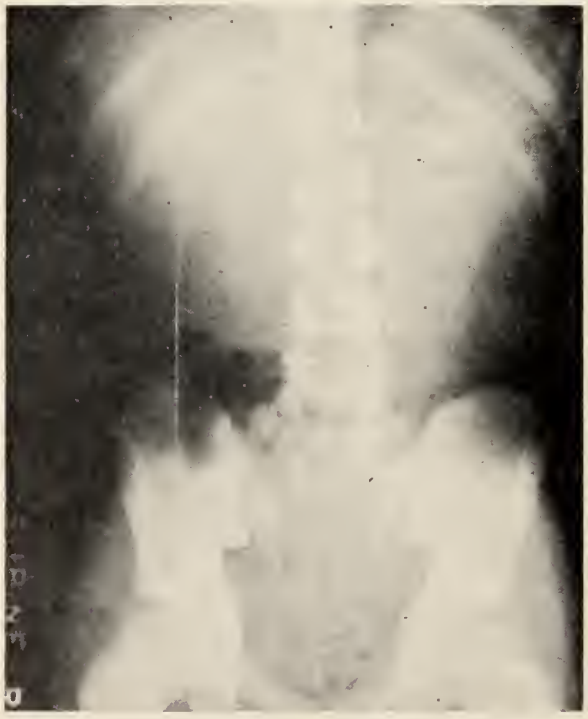


Fig. X (Case IV)—Scout film of the abdomen revealed a lumbar scoliosis with concavity to the right. There was partial loss of the right psoas shadow and right renal outline with homogenous areas of increased density in the right upper quadrant. Questionable free air was present about the kidney.



Fig. XI (Case IV)—Intravenous urogram showed a normal collecting system. There were suspicious areas of air about the right kidney, indicating a retroperitoneal perforation of the bowel.

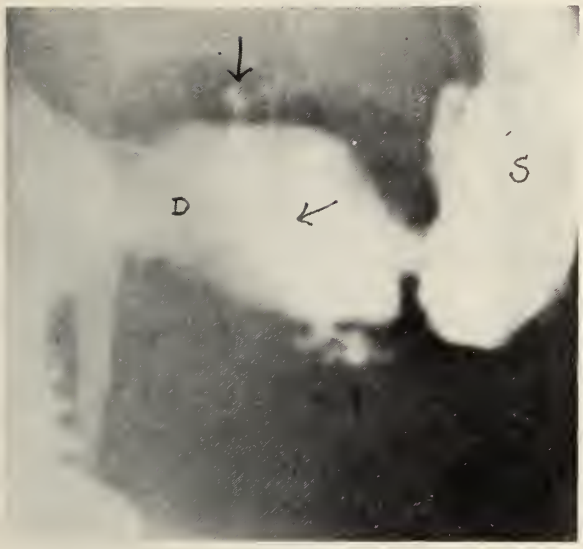


Fig. XII (Case IV)—Spot film of the antrum of the stomach (S) and duodenal cap (D) showed perforation of the superior wall of the duodenum (Central Arrow) with retroperitoneal extravasations (Other Arrows) of the opaque media.

the opaque media from the posterior aspect of the duodenal cap into the adjacent soft tissues. There was also evidence of a soft tissue mass compressing the duodenum in the region of the junction of the first and second portions, indicating hemorrhage and edema of the head of the pancreas. There was an adynamic ileus of the descending and transverse duodenum. Radiographic impression was rupture of the posterior aspect of the duodenum and traumatic pancreatitis.

After proper preoperative care the patient was taken to surgery and through a right upper quadrant transverse incision the abdomen was explored. Immediately it was apparent that there was a contusion of the contents of the right upper quadrant; particularly the colon, mesocolon, duodenum and pancreas. The head of the pancreas was edematous. No gross evidence of extravasation of pancreatic secretions could be seen. The only perforation of the bowel was in the duodenum about 2 cm. beyond the pyloric vein and on the posterior aspect of the cap. There was a transverse tear that had encompassed approximately one-third of the circumference of the duodenum. The edges of the perforation were slightly contused but relatively sharp. Inspection of the biliary tract revealed no evidence of extravasation. A posterior colic gastrojejunostomy was performed as a diversionary method of protecting the duodenal suture line. The patient tolerated this procedure well and his postoperative course was remarkably smooth until 12-24-67 when it was recognized that there was a fullness in the right upper quadrant, in spite of the previously placed drain. There was clinical evidence of inflammatory change in the operative site. The possibility of subhepatic abscess or pancreatic cyst was considered. Serum amylase study was done and found to be 328 units/100 ml. (Normal 60 to 160 units). The patient was taken to surgery again on 12-27-67.

A cystic area was entered which contained slightly cloudy fluid. A subsequent analysis of this revealed 5180 units of amylase—confirming the diagnosis of pseudocyst of the pancreas. Drains were, again, placed in position and secretions gradually decreased to approximately 75 cc. per day before the drains came out spontaneously. No further drainage occurred. There was no evidence of inflammation. The patient was discharged on 1-17-68, doing well. He returned to The Children's Hospital on 4-29-68 at which time the upper gastrointestinal study was repeated. This was reported as follows: "There was a normally functioning gastrojejunostomy. There was no evidence of jejunal ulceration. Media freely entered the duodenum and there was only a minimal amount of residual deformity in the region of the old perforation. The descending portion of the duodenum was compressed. This was felt to be due to edema in the old operative site rather than recurrence of the cyst."

Discussion

The indications for the various X-ray examinations are as follows:

Chest:

1) To establish a base line.

2) Check for aspiration pneumonitis.

3) Check for broken ribs.

Supine and Erect or Lateral Decubitus Films of the Abdomen to Check for:

1) Retroperitoneal or free air beneath the diaphragm.
2) Loss of psoas shadow.
3) Loss of normal outlines of viscera.
4) Abnormal masses.
5) Fractures of transverse processes.

Intravenous Urogram to Diagnose:

1) Contused kidney.
2) Ruptured kidney.
3) Established the presence of two kidneys.

Upper Gastrointestinal Studies to Diagnose:

1) Duodenal perforation.
2) Duodenal obstruction.
   a. Intramural hematoma.
   b. Retroperitoneal hemorrhage.

One cannot overemphasize the necessity for carrying out a routine study on every patient. The upper gastrointestinal examination may be excluded if there is free air beneath the diaphragm. A Levine tube will obscure the signs and symptoms of duodenal obstruction and cause unnecessary delay in the diagnosis if upper gastrointestinal examination is excluded because of overemphasis of the kidney findings as seen on intravenous urogram or the marked elevation of serum amylase.

Conclusion

Minimal epigastric trauma in children can give rise to severe injuries of multiple organs. A strict routine X-ray evaluation should be carried out including PA and lateral chest, supine erect or lateral decubitus films of the abdomen, intravenous urograms and opaque media studies of the upper gastrointestinal tract.

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The Psychologist As The Psychiatrist's Pathologist

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Introduction

The Hill Crest Hospital Staff has developed an organizational relationship with psychiatry and psychology that presents a unique and useful means of accurately diagnosing mental illness.

The technique involved centers about the division of Psychiatry and Psychology into separate departments, each functioning in its own capacity. The Psychiatric Department is involved in the clinical evaluation and treatment of the patient, whereas the psychological department confines its activities to evaluation of psychopathological test material. The key to this unique program is expressed in the thought that the *Psychologist is the Psychiatrist's Pathologist.*

The present paper describes a model of this type. It is not the intent of the authors to suggest that the system described is the only correct one, or even the best one, upon which a useful service pattern can be built. Rather, the intent is simply to describe a particular model, the philosophy behind it, the manner of its operation and the steps by which it developed.

The Conflict Between Psychiatry and Clinical Psychology

The history of the relationship between psychiatry and clinical psychology is one of cooperation and of conflict: cooperation because the needs of the patient dictated effective efforts to meet these needs; conflict because the two professions, neither secure in its own role definition, inevitably experienced conflicts in areas where activities overlapped.

Clinical psychology emerged into the clinical role from an academic background and tended to define the status of the practitioner by how much his time was given to the practice of psychotherapy. Psychiatry, emerging from a position of relatively low status among medical specialties, also seized upon psychotherapy as its unique role defining activity.

In recent years, however, resolution has appeared, partly because both groups have relied less and less upon psychotherapy as the unique role-defining activity of their profession. Practical considerations of patient need, of epidemiology of mental illness, and of shortages of trained personnel have convinced most of both disciplines that workable mental health cannot be based exclusively, or even primarily, upon the one-to-one psychotherapy treatment model.

The psychotropic drugs have changed the status of psychotherapy to that of one tool in the psychiatrist's armamentarium, an important one, perhaps, but only one tool among several.

At the same time, the development of scientific psychology has reawakened the psychologist's interest in diagnosis and he has assumed other service functions, which have reduced his dependency on psychotherapy as the only role-defining activity.

Hence, as each discipline has become more secure in a variety of functions, and as the one area of specific conflict has assumed

relatively less importance in each profession's activities, conflict has lessened and the opportunity for cooperation has increased. A major result of this has been exploration of new models of collaborative effort by creative workers of both groups.

The Emphasis Upon Diagnosis

During the past ten years changing concepts, goals and techniques of psychiatry have been pronounced. There is a demand for more action, a definite treatment goal, and less discussion and theory. With these new demands, it is apparent that accurate diagnosis of the psychopathology is increasingly important if the treatment is to be significantly goal directed.

Hill Crest Hospital is a private, active treatment center specializing in psychiatric illness. Inpatient and outpatient services are maintained, with an inpatient population of an average length of stay of 18.2 days. This results in an annual intake of over 1,000 patients, plus an outpatient load appropriate for the equivalent of two full-time psychiatrists.

The hospital staff is composed of five psychiatrists who come from varied backgrounds and training, including south, middle-west and eastern geographic centers. While the training in psychiatry has been varied from "organic" to "analytically oriented" in various members of the psychiatric group, the staff may be described as medically oriented. They believe that the evidence favors the concept that some mental illness may be true pathologic processes, organic in origin, possibly affected by hereditary influence, possibly biochemical in manner of effect upon the patient and probably more likely to respond to somatic therapy than to insight or re-education.

The validity of this position is not at issue here. What is important is that this position is held by the staff and that it produces an emphasis upon and a concern with matters of diagnosis. If one believes that maladjustment is one thing and schizophrenia is another and if experience indicates that these two different patterns are best treated in different ways, then the differential diagnosis becomes a matter of practical importance.

The psychologist in this setting shares the theoretical belief of the psychiatric staff. Although trained, as were most psychologists of his professional generation, overwhelmingly as an environmentalist, his work in multivariate test development and in the construction and maintenance of evaluation systems has led him to a diagnostic orientation and to a concept of emotional disturbance multiply determined. Again, the validity of this position is not at issue. The fact is that the psychologist's theoretical position is generally in agreement with that of the psychiatric staff.

Defining the Psychologist's Role

Given then a group of professionals who agreed that diagnosis was important and that overt symptom patterns did not necessarily reflect the nature of the underlying pathology, the question became one of how the psychologist could provide, at reasonable cost to the patient and rapidly enough for the Psychiatrist's needs, information that could be helpful in diagnosis.

Consideration of this matter began some years ago following conference between the psychologist and the psychiatrists with gradually developing agreement.

In the course of the discussions, several traditional services were contemplated and found redundant. For example, it was decided that since the staff of psychiatrists were experts in the use of interview techniques, duplication of this effort by still another staff member was unlikely to constitute the psychologist's unique contribution.

Similarly, an active social service department interviews family members, investigates patient histories and formulates a sociological description of the background of the patient's disturbance. Greater effort in

that area would be better served by an increase in the size of that department than by encouraging the psychologist to become, in effect, another social worker.

Finally, an expert staff of nurses, occupational therapists and attendants observe the patient eight hours a day. It seemed unlikely that brief observation of patients' behavior by the psychologist would add much in this area.

On the other hand, an obviously unique contribution which the psychologist can make to diagnosis concerns the development and interpretation of psychometric data.

The "Psychiatrist's Pathologist"

In a general hospital, it is the pathologist's place to gather, describe, analyze and report upon what might be called the "physiometric, biometric" and similar data. So it is felt that the psychologist's unique function in a psychiatric hospital is to perform similarly with psychometric data.

The pathologist does not diagnose, treat, or manage patients—he applies his knowledge to the analysis of data.

A "psychopathologist" functions in a similar manner. The psychiatrist diagnoses, treats, and manages patients while the "psychopathologist" limits his activities to the gathering, description, interpretation, and reporting of psychometric data. If the specialization is a meaningful one, such a psychologist should become efficient, objective and able to function at relatively low cost, as the pathologist does.

There is nothing unusual or startling in this concept. In one form or another, it has been one of the possible roles of the psychologist in a psychiatric setting since the beginning of clinical psychology as a profession. Previous practice, however, has not always carried the implications of this attitude to their logical ends. Two facts make this possible at Hill Crest:

(1) The Psychiatrists who manage the patient utilize the information that is furnished by the psychopathologist to the fullest possible extent, and

(2) The psychopathologist orients his work toward the real needs of the psychiatric staff, adopting both the philosophy and the manner of work of the pathologist in medicine.

Many psychologists trained in a psychiatric setting can testify to the frustration of developing voluminous quantities of material describing the patient and the concurrent knowledge that the main effect of all this activity will be reflected in the weight of the patient's files. This is not to say that psychiatrists have deliberately ignored the carefully documented and intensive patient studies conducted by the psychologist. Rather, it is a reflection of the fact that, in the early days of development of clinical psychology, psychiatrists were not particularly trained in the utilization of psychological data, nor were psychologists well trained in developing those data which would be of real use to the psychiatrist. It is only in the last few years that sufficient progress has been made to make real collaboration of this type possible.

The process described here requires adjustments in the philosophies of both the psychiatrists and the psychologists. The psychiatrist is required to orient his diagnostic process toward an end result that will successfully incorporate all the findings available, including psychometric data results. On the other hand, the psychologist must select those particular data that are likely to provide meaningful answers to questions which the psychiatric staff find important.

This does not mean that the psychologist cannot do research, that he cannot speculate upon things that are of interest in themselves, or that he cannot do any of the other luxurious things that scientists like to do. It does not mean that these things are not his primary job in the relationship described.

There is nothing, except perhaps the short-

age of time and research funds, to prevent the pathologist in a general hospital from spending all his spare time examining in meticulous detail some particular bit of tissue that comes his way. When a patient's body is sent for autopsy, however, or a bit of tissue is sent for study, the pathologist's interesting speculations about his own areas of interest do not constitute the report that is desired. Rather, he is asked to state, within the limits of his knowledge and competence, the probable cause of death, the possibility a certain lesion is tuberculosis or a certain tissue is malignant.

It is suggested that the psychologist who is to function in a comparable role must likewise address his skills toward the resolution of immediate problems of this type.

One other requirement exists if this type of relationship is to be fruitful: all of the participants must grant to one another the unqualified right to make errors.

This does not mean that errors of carelessness are to be tolerated: rather, it means that the professional must be free at all times to interpret his data in a manner that may cast doubt upon conclusions reached by others within the relationship. A psychiatrist who feels threatened when the psychometric data suggests something at variance with his own opinions about a patient cannot participate comfortably. Similarly, a psychologist cannot function efficiently who feels that his status constantly depends on the degree to which his latest set of interpretations matched the psychiatrist's previous impressions.

Given that the psychologist interprets the data as best he knows how, that these data are then reported to the psychiatrist in charge of a particular case, and that the psychiatrist then attempts to incorporate all the findings in his diagnostic formulation, only four possibilities exist.

(1) The psychiatrist's impressions and the psychologist's data agree, and both are correct.

(2) Equally possible, although hopefully not frequent, both sets of impressions agree, and both are wrong.

(3) The psychiatrist and the psychologist disagree, and the psychiatrist is right.

(4) The psychologist and the psychiatrist disagree, and the psychologist is right.

The patient may gain or lose in the cases where the two types of data agree; one would hope that most often he will gain. In the first case, the result for the patient should be a happy one. In the second, the result for the patient will be unhappy, and the profession will gain nothing that will be useful with the next patient of this type.

However, in the case of disagreement between the two types of data, as in three and four, both the medical specialty of psychiatry and the scientific discipline of psychology gain to the eventual benefit of all concerned, including the patient. In these cases, disagreement becomes a part of the continuing experience of both professionals, so that eventually the number of such disagreements will be reduced; it becomes a method by which the diagnostic skills of both the professionals are sharpened.

The records of these disagreements, printed in black and white in the files of the patients and engraved in the memories of the psychiatrist and psychologist involved, become the basis upon which scientific progress in this relationship is built.

Gathering and Processing Data

Based on the philosophy outlined above, a system of psychopathological activity within a psychiatric setting can be constructed. The task then becomes one of building and maintaining a system for gathering and processing data objectively, rapidly and economically.

At Hill Crest this task is begun by a technician who accepts the referral request from the psychiatrists (usually at staff meeting) and then proceeds to help the patient pro-

duce the data upon which the psychologist will base a judgment.

The psychologist does not see the patient; there is no necessity for him to know why the patient is in the hospital or psychiatric opinion regarding the patient. In fact, it is felt that it is an advantage that he not know these things. He is being asked to analyze data and to submit the results of this analysis for consideration by the physician who manages the treatment program. His analysis of the data may or may not be helpful. If it repeatedly fails to be helpful, he will find his services less and less in demand. Still, his analysis of the data is what is required, and the technician is perfectly competent to obtain the data that are needed.

TABLE 1

Instrument	Purpose
Wechsler Adult Intelligence Scale Wechsler Intelligence Scale for Children Wechsler-Bellevue Intelligence Scale, Form 11	Academic Intelligence
Sixteen Personality Factor Test (High School Personality Questionnaire, Child Personality Questionnaire)	Adjustment habits, temperament, interests, neurotic problems.
MMPI (printed or tape recorded)	Psychopathology, particularly psychosis and depression.
Culture Fair Intelligence Test (Tape recorded administration, Scale 2, Form A)	Intellectual potential, particularly with poorly educated persons.
Bender Gestalt Test	Brain Pathology
Benton Visual Retention Test	Brain Pathology
Rorschach Test	Further data re psychosis, depression, etc., particularly with patients who have distorted structured psychometrics.

The tests in Table 1 are those utilized in the Hill Crest system. They do not constitute a so-called routine battery: rather, the psychiatrist specifies in his referral the questions to which he desires answers, and the technician selects the appropriate instruments for obtaining the needed data. If the technician notes patient characteristics which seem at gross variance with what was described in the psychiatrist's referral, she reports to the psychiatrist and an extension of the referral request may be made. If the psychologist is not certain that all useful data have been obtained, he may request broader data. Similarly, if the psychiatrist, upon receiving the report, has reason to think that additional data would be valuable, he requests that such data be submitted to the psychologist for further study. Both requests are always honored.

Thus, the psychologist has built a system of data upon which he is willing to base pathological opinions. The psychiatrist specifies the questions to be answered, the technician follows the rules in obtaining the appropriate data, and the psychologist then attempts answers to the questions.

The "backbone" of this data system is the questionnaire material. The 16 Personality Factor Test (Cattell & Eber, 1962) describes the person's behavior in terms of a normal reference frame. That is, it describes the everyday habits and interests, the orientations and motivational tendencies, in terms of a system of factors known to be meaningful in the description of the normal personality.

It is a matter of empirical fact that these descriptive patterns also are most helpful in understanding certain types of psychopathology, particularly those types relating to neurosis, anxiety, acting-out behavior, superego patterns, dependency problems, and ability to function under conditions of emotional pressure, but not particularly helpful either in the identification or in the description of psychotic states.

The Minnesota Multiphasic Personality Inventory (MMPI, McKinley & Hathaway, 1943), on the other hand, is useful primarily in the identification of pathological states, particularly the psychotic manifestation or

states. This test was designed as an indicator of psychopathology and functions best in that area.

The combination of these two questionnaire instruments makes possible an adequate description of the way in which the patient functions as a normal person, and of the types of psychopathological states that must be considered in diagnosis.

Table 1 also shows certain test materials used to evaluate academic intellectual ability, relatively non-academic intellectual ability, evidence regarding brain pathology, and evidence regarding the thought and feeling processes of the person. This last matter includes the usual projective data that may be of help particularly in that case where the patient is unable or unwilling to give accurate descriptions of himself with the structures instruments.

When the technician has finished obtaining the data deemed relevant in a particular case, she performs all scoring and profiling, and then the entire data set is taken or sent to the psychologist's main office. Some of the data are keypunched for computer processing, and appropriate administrative records are completed. At that point, the data sent to the psychologist. Since he maintains his principal offices in two large cities and consulting relationships in three other locations, extensive use of air mail and similar rapid communication facilities insures that the data will be available to the psychologist, wherever he happens to be, the morning after the testing was completed.

The psychologist at that point begins a preliminary interpretation of the data, and then calls the hospital and records these preliminary impressions for typing and presentation to the psychiatric staff. The availability to the psychiatrist of preliminary impressions within 24 hours of the completion of the testing session means that patients do not have to have the expense of waiting in a hospital for treatment program to begin. Also, this preliminary report system takes some of the pressure off the psychologist in terms of his production and submission of the final report.

The specific data handled by the computer are the 16 PF materials. A standard available computer program is used to write a partial narrative report from the input scores (Eber, 1965, Cattell, 1965). Other data are considered by the psychologist primarily in terms of his judgment, but the fact that every report begins with the computer analysis of the 16 PF materials gives objectivity and stability to the entire system. (The discussion of the desirability of computer analysis is not appropriately carried on within this paper. A good review may be found in Cattell, 1965).

The entire system is extremely economical, both in terms of the conservation of the psychologist's time and in terms of the minimization of drain upon the patient's financial resources. Cost to the patient is determined by the specific instruments used, which in turn is determined by the referral questions posed by the psychiatrist. This is in keeping with the usual practice in the physical pathologist's laboratory. At the present time, these costs to the patient vary between $25 for relatively simple routines and $40 for the most complex and detailed data set.

One may wonder regarding the level of training needed by the technician who obtains the necessary data in this system. The lady who performs these duties at Hill Crest has college training at approximately the master's level, but does not have a formal master's degree. She has broad and varied experience in education and in other areas related by psychology, but has had no specific graduate training in psychology and no previous training in a clinical psychological setting except that experience gained working for the psychologist who designed and maintains this system. She is a mature woman of good intelligence, with stable and dependable work habits, and she is a person who is willing to learn proper techniques and who finds a rewarding role in performing the duties assigned. She is neither frustrated by the

limited nature of her duties nor bored by them, yet she also does not underestimate the importance of these duties in a system where everything depends upon accurate and dependable performance of such duties.

Summary

A few other comments regarding the system may be in order. One concerns the possibility of the employment of a similar system in another location. The writers can see no reason why any psychologist desiring to do this could not achieve a similar system. The test materials utilized are standard and available from standard sources. The computer reporting of the 16 PF is available through air mail service and would add only another day to the elapsed time between testing and final report in the case of a psychologist anywhere in the United States. Moreover, a psychologist in another situation may well find that his own preferences and the demands of the situation suggest that different techniques be used than the ones specified here. There is no attempt to state that these are the only techniques that can be used in this manner, or that they are necessarily the best ones. They happen to be the ones that seem to be doing the job in this situation, and that are appropriate to the skills and preferences of this psychologist. The basic concept of a pathology laboratory is not dependent upon the specific techniques used, any more than the performance of a pathologist in a general hospital is determined by the specific tools with which he chooses to equip his laboratory. Tools are important, but they are only tools.

An important outgrowth of the systematic approach to meeting the needs of a psychiatric hospital has been the development of a large file of standardized information describing the psychometric characteristics of the patients. Substantial research efforts are possible with this wealth of data, and some studies are currently underway.

Finally, our system has proved useful and practical in diagnosis and rapid and accurate assessment of the patient's needs data analysis. However, we think a great part of our success is due to the smooth functioning of the psychological and psychiatric departments. The psychologist functioning as the pathologist of psychiatry has defined our roles, prevented overlapping, eliminated friction, and helped both departments to achieve a symbiotic relationship in the treatment of the individual patient.

In summary, the purpose of this paper has been to describe a system by which a psychologist can develop and communicate information that is helpful to the staff of a private psychiatric hospital in an effort to make the diagnostic process as effective as possible. It is suggested that similar systems might be utilized in other situations.



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Warnings—Watch for the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism, retinal thrombosis); if present or suspected discontinue the drug immediately.

British studies reported in April 1968[1,2] estimate there is a seven-to tenfold increase in mortality and morbidity due to thromboembolic diseases in women taking oral contraceptives. In these controlled retrospective studies, involving 36 reported deaths and 58 hospitalizations due to "idiopathic" thromboembolism, statistical evaluation indicated that the differences observed between users and non-users were highly significant. The conclusions reached in the studies are summarized in the table below:

Comparison of Mortality and Hospitalization Rates Due to Thromboembolic Disease in Users and Non-Users of Oral Contraceptives in Britain.

Category	Mortality Rates		Hospitalization Rates (Morbidity)
	Age 20-34	Age 35-44	Age 20-44
Users of Oral Contraceptives	1.5/100,000	3.9/100,000	47/100,000
Non-Users	0.2/100,000	0.5/100,000	5/100,000

No comparable studies are yet available in the United States. The British data, especially as they indicate the magnitude of the increased risk to the individual patient, cannot be applied directly to women in other countries in which the incidences of spontaneously occurring thromboembolic disease may differ.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or sudden onset of proptosis, diplopia or migraine. Withdraw medication if papilledema or retinal vascular lesions are found.

Since the safety of Ovulen in pregnancy has not been demonstrated, it is recommended that pregnancy be ruled out for any patient who has missed two consecutive periods before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the first missed period.

A small fraction of the hormone agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions—Pretreatment physical examination should include special reference to the breasts and pelvic organs, and a Papanicolaou smear.

Endocrine and possibly liver function tests may be affected by Ovulen. Therefore, it is recommended that such tests if abnormal be repeated after the drug has been withdrawn for two months.

Pre-existing uterine fibromyomas may increase in size under the influence of progestogen-estrogen preparations.

Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation.

In breakthrough bleeding, and all irregular vaginal bleeding, consider nonfunctional causes. Adequate diagnostic measures are indicated in undiagnosed vaginal bleeding.

Carefully observe patients with a history of psychic depression and discontinue the drug if severe depression recurs.

Any possible influence of prolonged Ovulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study.

A decrease in glucose tolerance has occurred in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be observed carefully while receiving Ovulen.

Because of the effects of estrogens on epiphyseal closure Ovulen should be used judiciously in young patients in whom bone growth is not complete.

The age of the patient constitutes no absolute limiting factor, although Ovulen therapy may mask the onset of the climacteric.

The pathologist should be informed of Ovulen therapy when relevant specimens are submitted.

Adverse Reactions—A statistically significant association has been shown between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: cerebrovascular accidents, neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement, secretion), change in weight, changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, allergic rash, rise in blood pressure in susceptible individuals, mental depression.

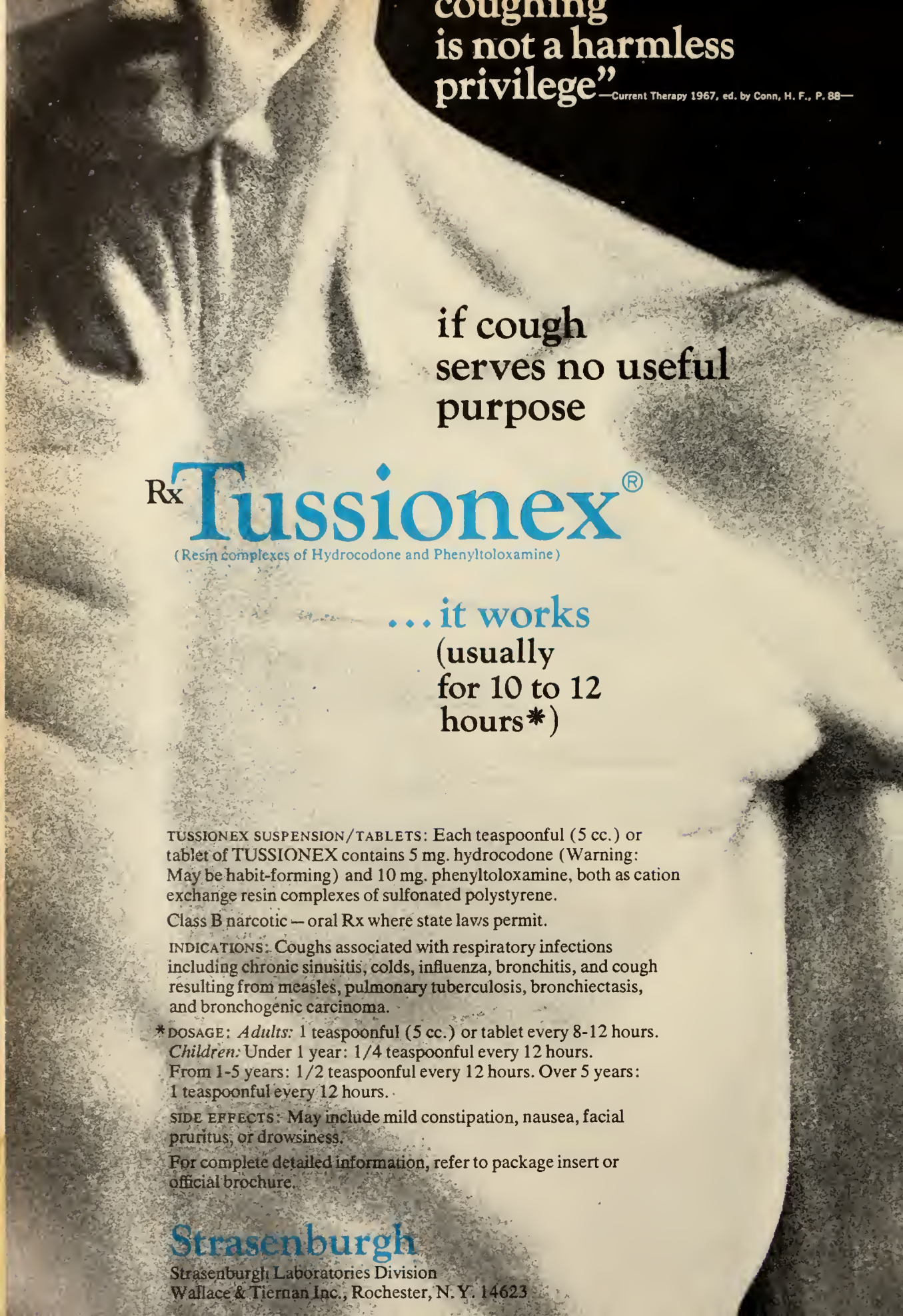
Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme and nodosum, hemorrhagic eruption, itching.

The following laboratory results may be altered by oral contraceptives: hepatic function: increased sulfobromophthalein and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T^3 uptake values; metyrapone test; pregnanediol determination.

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*DOSAGE: *Adults:* 1 teaspoonful (5 cc.) or tablet every 8-12 hours. *Children:* Under 1 year: 1/4 teaspoonful every 12 hours. From 1-5 years: 1/2 teaspoonful every 12 hours. Over 5 years: 1 teaspoonful every 12 hours.

SIDE EFFECTS: May include mild constipation, nausea, facial pruritus, or drowsiness.

For complete detailed information, refer to package insert or official brochure.

Strasenburgh

Strasenburgh Laboratories Division
Wallace & Tiernan Inc., Rochester, N.Y. 14623

Hospital Staff Membership—Privilege or Right?

Reginald T. Hamner, LL. B.

The importance of access to hospital facilities was reaffirmed in a decision of the U. S. Fifth Circuit Court of Appeals in a case having risen in Alabama.[1] Though the plaintiffs in the action were two Negro physicians, the Court held racial discrimination provided no basis for suit as a class action. The trial court had found there was no evidence of racial discrimination on the part of the defendant hospital board in the trial of the case.

Suit was instituted in the U. S. District Court, Southern District of Alabama, by two physicians after they were denied admission to the medical staff of the county hospital. From an adverse decision in which the lower court denied injunctive relief, the plaintiffs appealed.

The Fourteenth Amendment to the Constitution of the United States, which forbids any state to make or enforce any law which would deny to any person the equal protection of the law, was cited by the Appellate Court as the authority for reversing the lower court and instructing the trial court to enjoin the hospital from limiting access to its medical staff on the basis of its bylaw. The state involvement which was required for application of this amendment was undisputed. The hospital board received both state and federal funds and was thus a public institution whose acts were state acts.

The bylaws upon which the denial was predicated required (1) that all applicants for membership be members of the medical society of the county and (2) that each application be signed by two members of the active medical staff who were acquainted with the applicant, attesting that he had such character and general fitness as justified his being granted hospital privileges.

These two requirements were deemed to be unreasonable. Equal treatment of members of the same class (in this instance, physicians) is a fundamental requisite of equal protection rights. Any distinction between such members must be on a reasonable basis and the distinction must in some way relate to the purpose for which a classification is made.

The bylaws of the hospital in question stated the expressed purpose for the formation of the medical staff was the insurance that all patients admitted to the hospital or treated in the out-patient department receive the best possible care.

The bylaws made a distinction between members and non-members of the society—all members of the same profession. The Court decided the distinction made was not related to the expressed purpose for which the medical staff was formed.

The dual endorsement required was not reasonable, the Court held, since the endorsements "may be arbitrarily and discriminatorily withheld." It was noted by the Court there was no appeal procedure for one who did not receive the required endorsements and further there was no means through which qualifications could be presented. Lacking also was a right to be informed of one's basis for exclusion.

Reasonable conditions are impossible, and such could be related to professional and ethical qualifications or the common good of the problem.

Staff membership was a prerequisite for admitting and treating patients in this only public and largest hospital in the area in question. Citing a California Appellate

1. *Foster v Mobile County General Hospital,* 398 F. 2d 227, 37L. W 2037 (1968)

Court decision[2], the Court emphasized the importance of a physician's right to practice medicine in a hospital where it said:

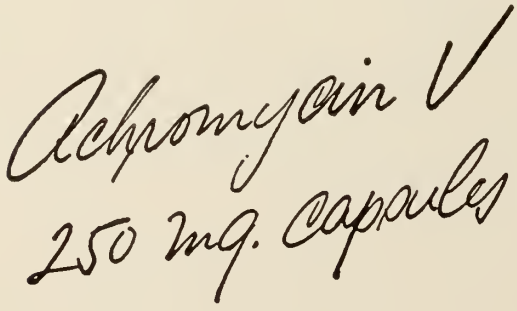
> "It is common knowledge that a physician or surgeon who is not permitted to practice his profession in a hospital is as a practical matter denied the right to fully practice his profession. In this day of advanced medical knowledge and advanced diagnostic techniques much of what a physician or surgeon must do can only be performed in a hospital."

The Court noted the patient too was being denied the use of the hospital's facilities unless he was referred to a staff member and this in turn would reduce the remuneration due the non-members for the care of his patients.

Without declaring it to be so, it can be reasonably inferred that hospital staff membership is a right where a physician possesses the requisite professional qualifications as regards education and training and the hospital is a "state activity."

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2. *Wyatt v Tahoe Forest Hospital District*, 174 Cal App 2d 709, 345 P. 2d 93 (1959)



ACHROMYCIN® V
TETRACYCLINE HCl Lederle
481D-9

Are Medical And Related Health Careers Losing Their Allure?

But for the nursing schools, Alabama graduates in medicine and related professions would have shown a sharp drop in 1968 over 1967, according to recently released statistics of the Health Careers Council of Birmingham.

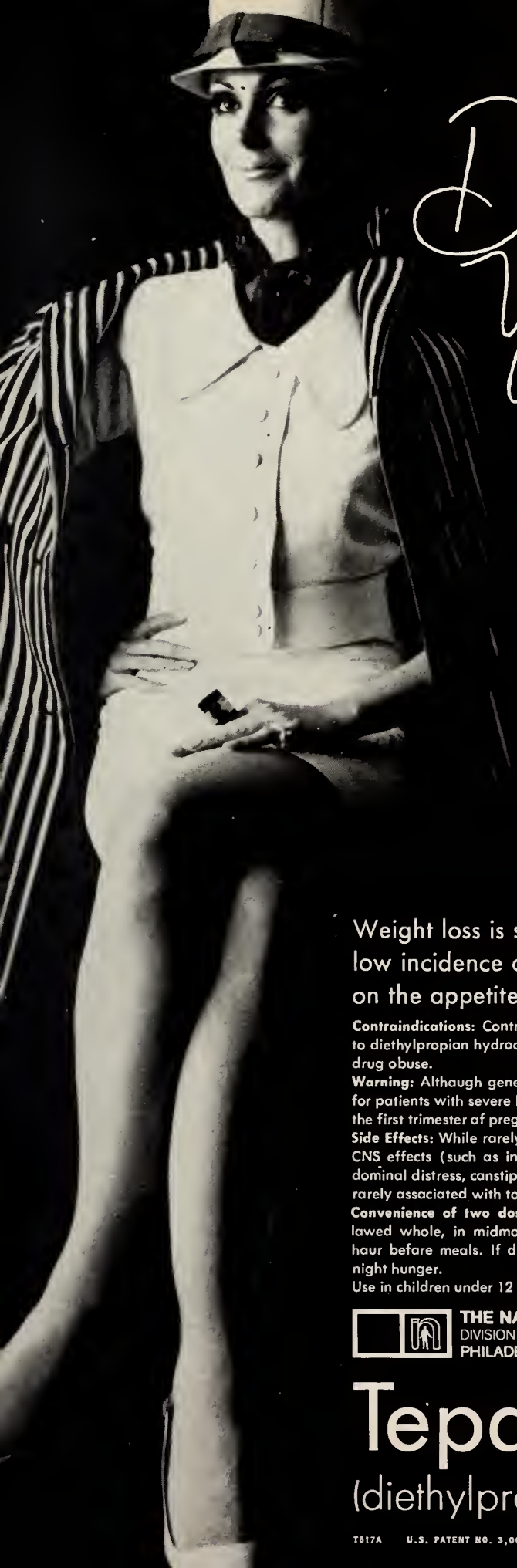
There were 99 more graduates of nursing schools and 24 more practical nursing, with which might be contrasted three fewer graduates in medicine, five fewer in medical technology, 33 fewer in pharmacy, and proportionate declines in graduates of other divisions of the professional areas.

While enrollment figures are up and student interest, according to HCC Director Parnell Langston, "seems to be greater," the gap between actual enrollment and the number who made applications remains essentially the same.

In 1967 there were 449 applications for medical school, and in 1968 the figure rose to 705. In both years the total number of freshmen admitted was 85.

Applicants for admission to nine schools for classes in Medical Technology totaled 100 in 1967, and 165 in 1968; totals of the freshman class were 47 and 62 respectively. For classes in X-ray Technology in these nine schools the applicants were 256 and 237 respectively, with an actual freshman class in 1967 of 75, in 1968 of 69, while graduates in both years totaled 45.

By contrast, in 11 nursing schools there were 759 applicants in 1967 with 530 enrolled, while in 1968 there were 1191 applications with 631 enrolled. Graduate nurses in those years were 278 and 377 respectively.



Dear Doctor,
You made me
what I am today
a whole lot
slimmer!

TEPANIL —the right start in support of the weight-control program *you* recommend. It reduces the appetite. Doesn't kill it. Weight loss is significant—gradual—yet there is a relatively low incidence of CNS stimulation. Because TEPANIL works on the appetite, not on the "nerves."

Contraindications: Contraindicated cancurrently with MAO inhibitars, in patients hypersensitive to diethylpropian hydrochlaride, and in ematianally unstable patients known to be susceptible ta drug obuse.

Warning: Althaugh generally safer than the omphetomines, use great caution when prescribing for patients with severe hypertension or severe cardiovascular diseose. Shauld not be used during the first trimester af pregnancy unless patential benefits autweigh potential risks.

Side Effects: While rarely causing therapy to be withdrawn, side effects moy occur occasianally; CNS effects (such as insamnja, nervausness, jitteriness), dryness af mouth, thirst, nausea, abdominal distress, canstipatian, headache, allergic response including urticaria or other dermatitis; rarely assaciated with tachycardia, cardioc arrhythmia or ECG chonges.

Convenience of two dosage forms: TEPANIL Ten-tab tablets: One 75 mg. tablet daily, swallawed whole, in midmorning (10 a.m.); TEPANIL: One 25 mg. tablet three times daily, one haur befare meals. If desired, an additional toblet may be given in midevening to avercame night hunger.

Use in children under 12 years af age is not recommended.

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(continuous release form)

(diethylpropion hydrochloride)

T817A U.S. PATENT NO. 3,001,910 1/69

Outlook For The Economy

W. L. Whiting, III

In last month's article, I discussed the New Administration and the Outlook for the Economy. I would like to conclude the discussion by analyzing three critical components of the economy that government actions will affect this year.

Military Spending

The outlook for military spending has changed considerably in recent months. The Russian invasion of Czechoslovakia and the election of Mr. Nixon will probably result in continued high levels of military spending even if the Vietnam war ends. In fact, the apparent need for more American cold-war spending and the new Administration's interest in greater military preparedness have made an early peace essential. Otherwise, a shift to a wartime economy, with price and wage controls and other politically distasteful measures, would be necessary.

Even though we expect the Vietnam war to be settled in the not-too-distant future, defense spending is unlikely to dip much below the present $80-billion annual rate for very long. Cutbacks in spending for Vietnam will probably be initially offset by expenditures to restock military investories and to add conventional arms and troops in Europe and in other cold-war areas—possibly even in the potentially explosive Middle East. Later, spending on strategic weapons, which was postponed partly because of Vietnam, should rise substantially as the antiballistic-missile and other programs move from the development to production stages. Continued military and reconstruction efforts in Southeast Asia may also be necessary.

Consumer Behavior

Consumer behavior this year has been somewhat erratic. After saving at extremely high rates in the first half, consumers went on a spending spree in the third quarter, just when the surtax sharply reduced the growth in take-home pay. Buying of automobiles in anticipation of price increases seems to have been partly responsible. Furthermore, many consumers apparently maintained their previously-laid spending plans initially, and cut their saving to pay the higher taxes. Others did not even need to reduce their saving; the increase in consumer income in the third quarter more than offset higher personal taxes. The expectation that further pay raises can be obtained probably also fostered consumer optimism and encouraged spending.

We believe, however, that consumer spending is growing more slowly currently and will continue to do so in coming quarters. Recent retail-sales figures suggest that consumers are gradually adjusting to the surtax and to a slower growth in pretax incomes. After the middle of 1969, a consumer behavior will depend on the life of the surtax and on the Vietnam war. Assuming, as we do, that the surtax will expire and that the war will have ended by the middle of 1969, a consumer-spending boom will probably get under way in the second half. After an estimated 8% advance in 1968, consumer spending in 1969 may grow only about 5% for the year as a whole. In the second half of next year, however, a 7% annual rate of growth seems to be likely.

The Over-All Outlook

Putting together our forecasts of military, consumer behavior, and home-building, we find that the middle of 1969 may mark an important turning point for the over-all economy. Until then, business will be fairly dull, and economic growth will little more than offset inflation. In the second half of 1969,

(Continued on Page 828)

Mr. Whiting is account executive for Merrill Lynch, Pierce, Fenner and Smith, Inc., in Mobile, Alabama.

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Obesity Oddities

FACT & LEGEND



CONTROL FOOD AND MOOD ALL DAY LONG WITH A SINGLE MORNING DOSE

AMBAR #2 EXTENTABS®

methamphetamine HCl 15 mg., phenobarbital 64.8 mg. (1 gr.)
(Warning: may be habit forming).

One Ambar Extentab before breakfast can help control most patients' appetite for up to 12 hours. Methamphetamine, the appetite suppressant, gently elevates mood and helps overcome dieting frustrations. Phenobarbital, the sedative in Ambar, controls irritability and anxiety... helps maintain a state of mental calm and equanimity. Both work together to ease the tensions that erode the willpower during periods of dieting.

Also available: Ambar #1 Extentabs®—methamphetamine hydrochloride 10 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

BRIEF SUMMARY/**Indications:** Ambar suppresses appetite and helps offset emotional reactions to dieting. **Contraindications:** Hypersensitivity to barbiturates or sympathomimetics; patients with advanced renal or hepatic disease. **Precautions:** Administer with caution in the presence of cardiovascular disease or hypertension. **Side Effects:** Nervousness or excitement occasionally noted, but usually infrequent at recommended dosages. Slight drowsiness has been reported rarely. See package insert for further details.

A. H. ROBINS COMPANY, RICHMOND, VA. 23220 A-H-ROBINS

OUTLOOK FOR THE ECONOMY

(Continued from Page 826)

however, rapid growth should resume, and gross national product is expected to rise at an 8% annual rate. For 1969 as a whole, we expect GNP to be about $910 billion (5½% greater than GNP in 1968) after rising 8½% this year to $860 billion. It appears more useful, however, to look at the period before and the period after mid-1969 than at the current and next calendar years.

With economic growth slowing between now and mid-1969, the unemployment rate is likely to rise somewhat from the recent 3½% level, but will probably stay below 4½%. As in recent periods of slow growth, employers will probably anticipate a quick return to full employment, and may again reduce over time and allow some unneeded workers to remain on the job. But workers who may be critically needed only a few months later will probably not be laid off. Productivity, or output per man-hour, may suffer, but minority groups and youths will not be hit with massive layoffs. After mid-1969, the surging economy will cause sizable gains in employment, and the unemployment rate will probably drop below the 4% level by year-end.

Restrictive credit policies and strong demand for credit will probably hold interest rates at about current levels until early next year. The substantial easing expected in monetary policy, however, should subsequently result in some sharp declines in interest rates. Short-term rates may fall substantially as credit eases and the effects of a less buoyant economy and less inflationary pressure are felt. A reduced Federal deficit and shrinking Federal demands for credit will also exert downward pressure on short-term interest rates. Long-term interest rates will probably decline less in view of the expected heavy demand for mortgage money and expectations of continuing inflation. Later next year, both short-and long term rates will probably rise somewhat as economic activity accelerates and credit demands increase.

"Center Of Information On Birth Defects" Set Up In Birmingham

A "Center of Information for Birth Defects," supported by the National Foundation, March of Dimes, is now established in the Out-patient Services Building of the Medical Center, Birmingham, under direction of Dr. John W. Simpson, associate Clinical Professor of Pediatrics, a past president of the Medical Association of the State of Alabama.



Dr. Simpson

A complete file of children born with defects is to be kept, along with records and recommendations of referrals. Every kind of defect will be classified and filed, readily available for any doctor needing guidance in the handling of an individual case.

Dr. Simpson, who qualified for membership in MASA's 50-Year Club last year, and who will be 80 years old next November 18th, was honored at a testimonial dinner on December 12, 1963, by the staff of the Childrens Hospital, in Birmingham, when Dr. Hughes Kennedy, Jr., was master of ceremonies.

Three doctors paid tribute to the honoree at that time, Dr. Harry C. Shirkey, Birmingham, speaking on "John Simpson and the Childrens Hospital"; Dr. George A. Denison, also of Birmingham, on "John Simpson and the Health of Jefferson County"; and Dr. Charles A. Weymuller, New York, once a Resident in Pediatrics with Dr. Simpson at St. Christophers Hospital for Babies, Brooklyn, on "John Simpson and Pediatrics."

Dr. Simpson was president of the Medical Association of the State of Alabama in 1962.



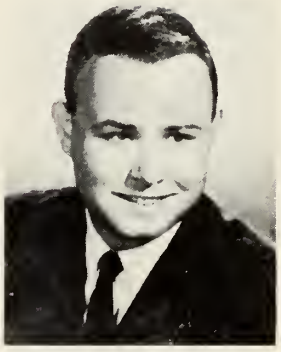
around the state

New Physicians Licensed To Practice In Alabama



Richard Robin Anthony, M. D., University of Tennessee College of Medicine, 1965, Reciprocity with Mississippi—Intends to locate in Hartselle.

Michael Jay Bradford, M. D., Harvard Medical School, 1964, National Board of Medical Examiners—Intends to locate in Montgomery (Maxwell AFB).





Charles Houston Allen, Jr., M. D., University of Mississippi School of Medicine, 1957, Reciprocity with Mississippi—Intends to locate in Fulton.



Matthew Lynwood Burns, M. D., Emory University School of Medicine, 1961, Reciprocity with Georgia—Intends to locate in Montgomery.



John Bostwick, III, M. D., University of Tennessee College of Medicine, 1966, Reciprocity with Georgia—Intends to locate in Opelika.

David Alford Ball, M. D., University of Mississippi School of Medicine, 1967, Reciprocity with Mississippi—Intends to locate in Montgomery.





Jack Lee Crain, M. D., University of Arkansas School of Medicine, 1966, Reciprocity with Arkansas—Intends to locate part-time in Atmore and Fulton.



Charles Ely Flowers, Jr., M. D., Johns Hopkins University, 1944, Reciprocity with North Carolina—Intends to locate in Birmingham.

Charles Francis Clark, M. D., Johns Hopkins University School of Medicine, 1964, Reciprocity with Colorado—Intends to locate at Fort McClellan.

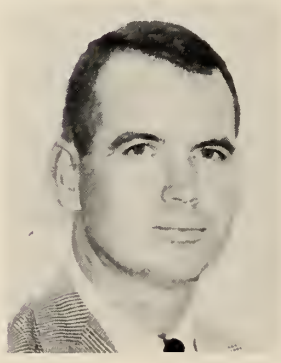


George Earle Fuller, M. D., Emory University School of Medicine, 1962, Reciprocity with Georgia—Intends to locate in Opelika.





George Washington Davis, III, M. D., Western Reserve University School of Medicine, 1960, Reciprocity with Ohio—Intends to locate in Birmingham.



David Black Gillis, Jr., M. D., University of North Carolina School of Medicine, 1964, Reciprocity with North Carolina—Intends to locate in Fort Rucker.

Guy Bryan Dewees, III, M. D., Harvard Medical School, 1962, Reciprocity with National Board of Medical Examiners—Intends to locate in Birmingham.



George Aaron Hallenbeck, M. D., Northwestern Medical School, 1940, Reciprocity with Minnesota—Intends to locate in Birmingham.



(Continued on Page 836)

See next page for prescribing informat



You've made it one of your specifics in acute otitis media

DECLOMYCIN®
DEMETHYLCHLORTETRACYCLINE



You've made it one of your specifics in acute otitis media

DECLOMYCIN acts against many strains of H. influenzae, pneumococci and streptococci, the most common invaders. In otitis media, where it is difficult to isolate the causative organism, this coverage may be important. However, some strains may be resistant and other pathogens can be involved.

You've found the high serum levels of DECLOMYCIN important, too. Its prolonged action permits convenient 300 mg b.i.d. or 150 mg q.i.d. administration.

When specimens are obtainable, your culture studies will indicate the usefulness of DECLOMYCIN.

Effectiveness: DECLOMYCIN Demethylchlortetracycline should be equally or more effective therapeutically than other tetracyclines in infections caused by organisms sensitive to the tetracyclines.

Contraindication: History of hypersensitivity to demethylchlortetracycline.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis pruritus ani. Skin—maculopapular and erythematous rashes; a rar case of exfoliative dermatitis has been reported. Photosensitivity onycholysis and discoloration of the nails (rare). Kidney—rise in BUN apparently dose-related. Transient increase in urinary output, some times accompanied by thirst (rare). Hypersensitivity reactions—urti caria, angioneurotic edema, anaphylaxis. Teeth—dental staining (ye low-brown) in children of mothers given this drug during the latter hal of pregnancy, and in children given the drug during the neonatal per od, infancy and early childhood. Enamel hypoplasia has been seen i a few children. If adverse reaction or idiosyncrasy occurs, discontinu medication and institute appropriate therapy. Demethylchlortetra cycline may form a stable calcium complex in any bone-forming tissu with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Shoul be given 1 hour before or 2 hours after meals, since absorption i impaired by the concomitant administration of high calcium conter drugs, foods and some dairy products. Treatment of streptococc infections should continue for 10 days, even though symptoms hav subsided.

DECLOMYCIN®
DEMETHYLCHLORTETRACYCLINE

Capsules: 150 mg; **Tablets:** film coated, 30 mg, 150 mg and 75 mg of demethylchlortetracycline HCl. 398

LEDERLE LABORATORIES, A Division of
American Cyanamid Company, Pearl River, New York

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now she can cope...

thanks to

Butisol SODIUM®
(SODIUM BUTABARBITAL)

the "daytime sedative" for everyday situational stress

When stress is situational—environmental pressure, worry over illness—the treatment often calls for an anxiety-allaying agent which has a prompt and predictable calming action and is remarkably well tolerated. BUTISOL SODIUM (sodium butabarbital) meets this therapeutic need.

After 30 years of clinical use . . . still a first choice among many physicians for dependability, safety and economy in mild to moderate anxiety.

Contraindications: Porphyria or sensitivity to barbiturates.

Precautions: Exercise caution in moderate to severe hepatic disease. Elderly or debilitated patients may react with marked excitement or depression.

Adverse Reactions: Drowsiness at daytime sedative dose levels, skin rashes, "hangover" and systemic disturbances are seldom seen.

Warning: May be habit forming.

Usual Adult Dosage: As a daytime sedative, 15 mg. (¼ gr.) to 30 mg. (½ gr.) t.i.d. or q.i.d.

Available for daytime sedation: Tablets, 15 mg. (¼ gr.), 30 mg. (½ gr.); Elixir, 30 mg. per 5 cc. (alcohol 7%).

BUTICAPS® [Capsules BUTISOL SODIUM (sodium butabarbital)] 15 mg. (¼ gr.), 30 mg. (½ gr.).

McNEIL

McNeil Laboratories, Inc., Fort Washington, Pa.





If you think the pink pill for U.R.I. symptoms is built for speed and endurance you're on the right track.

Here is a tablet that begins to relieve symptoms of upper respiratory infection quickly—a tablet that works for hours to make it easy for your patient to enjoy continuous relief.

Novahistine Singlet combines effective dosage of an antipyretic-analgesic with a vasoconstrictor-antihistamine formulation to relieve not only the congestion, but also the fever and the aches and pains that almost always accompany upper respiratory infections

A total daily dosage of 3 or 4 tablets will normally provide the continuous relief your patient expects. Use with caution in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

PITMAN-MOORE Division of The Dow Chemical Company, Indianapolis, Indiana.

Novahistine®
Singlet decongestant-analgesic

(Each tablet contains: phenylephrine hydrochloride, 40 mg.; chlorpheniramine maleate, 8 mg · acetaminophen, 500 mg.)

DOW

(Continued from Page 830)



Samuel Lee Hollobaugh, M. D., Ohio State University College of Medicine, 1962, Reciprocity with Ohio—Intends to locate in Birmingham.



Peter Biggs Hukill, M. D., Yale University School of Medicine, 1953, Reciprocity with National Board of Medical Examiners — Intends to locate in Birmingham.

James P. Himmelwright, M. D., Northwestern University Medical School, 1963, Reciprocity with New Mexico —Intends to locate at Maxwell AFB (Considering Opelika).



Thomas Naum James, M. D., Tulane University School of Medicine, 1949, Reciprocity with Michigan—Intends to locate in Birmingham.





William Francis Henson, Jr., M. D., Howard University College of Medicine, 1959, Reciprocity with National Board of Medical Examiners—Intends to locate in Tuskegee.



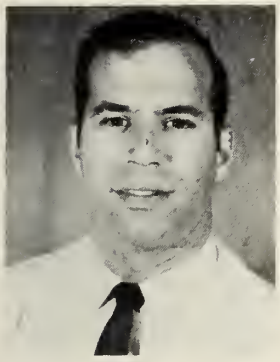
Calvin Robert Johns, Jr., M. D., Howard University College of Medicine, 1962, Reciprocity with Georgia—Intends to locate in Tuskegee.

Clark Miller Hinkley, M. D., University of North Carolina School of Medicine, 1961, Reciprocity with North Carolina—Intends to locate in Birmingham.



David Allen Justice, M. D., Medical College of Georgia, 1966, Reciprocity with Georgia—Intends to locate in Heflin.





Lawrence Klein, M. D., Northwestern University Medical School, 1963, Reciprocity with National Board of Medical Examiners—Intends to locate in Montgomery (Maxwell AFB).

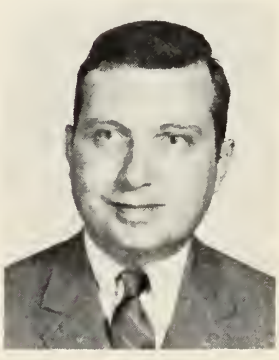


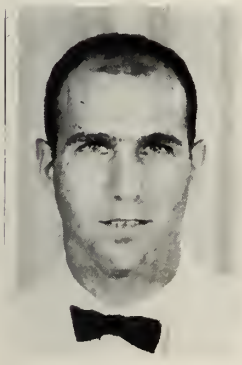
Lawrence Michaels, M. D., McGill University, 1959, Reciprocity with National Board of Medical Examiners—Intends to locate in Alexander City.

Meron Jacob Levitats, M. D., State University of New York, Downstate Medical Center, 1963—Reciprocity with National Board of Medical Examiners—Intends to locate in Montgomery (Maxwell AFB).



Ronald Kent Montgomery, M. D., Emory University School of Medicine, 1963, Reciprocity with Georgia—Intends to locate in Mobile.





Elliot Lee Marcus, M. D., Duke University School of Medicine, 1963, Reciprocity with North Carolina—Intends to locate in Huntsville.



Avrin Mauryce Overbach, M. D., University of Minnesota Medical School, 1966, Reciprocity with Minnesota—Intends to locate in Birmingham.

John Finley McRae, Jr., M. D., Tulane University School of Medicine, 1961, Reciprocity with Louisiana—Intends to locate in Birmingham.



John Mallory Packard, M. D., Harvard Medical School, 1945, Reciprocity with Florida—Intends to locate in Birmingham.



(Continued on Page 840)

Symbols in a life of psychic tension

B.A.
cum laude

V.P.
at thirty-two

ECG
and complete examination normal (persistent palpitations)



ROCHE
Roche
LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110



Rx

Valium® (diazepam) *t.i.d.* and *h.s.*

B.A. (*cum laude*)...V.P. (at thirty-two)...symbols that illuminate the quality of a life...the satisfactions of achievement, as well as its price...the pressures and stresses that can often create cardiac manifestations of psychic tension. For this kind of patient—with no demonstrable pathology—consider the singular benefits of Valium (diazepam).

With its pronounced calming action, Valium can relieve psychic tension promptly, attenuating its somatic signs and symptoms. Further, Valium is distinctly useful when somatic and depressive symptomatology (secondary to psychic tension) coexist. And Valium is generally well tolerated; in proper maintenance dosage, it seldom dulls the senses or interferes with functioning.

When psychic tension-related insomnia appears, an *h.s.* dose added to the *t.i.d.* schedule helps promote sleep.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Valium® (diazepam)

2-mg, 5-mg, 10-mg tablets *t.i.d.* or *q.i.d.*

to help relieve psychic tension
and its somatic symptoms

(Continued from Page 837)

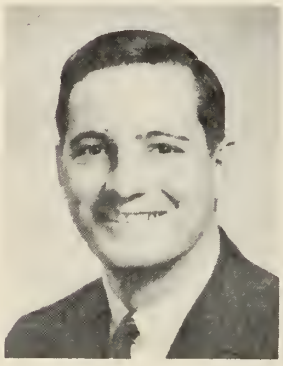


Charles Edward Rackley, M. D., Duke University School of Medicine, 1958, Reciprocity with North Carolina—Intends to locate in Birmingham.



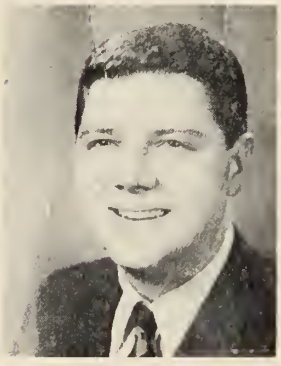
Leslie J. Stubblefield, M. D., University of Tennessee College of Medicine, 1952, Reciprocity with Tennessee—Intends to locate in Auburn.

John Hembree Rand, M. D., University of Tennessee College of Medicine, 1965, Reciprocity with Tennessee—Intends to locate in Opelika.



Stephen Howard Kassel, M. D., University of Illinois College of Medicine, 1964, Reciprocity with Florida—Intends to locate at Fort Rucker.





Mitchell Robert Smigiel, Jr., M. D., Marquette University School of Medicine, 1967, Reciprocity with National Board of Medical Examiners—Intends to locate in Montgomery (Maxwell AFB).



Thomas Murray Turner, M. D., Meharry Medical College, 1963, Reciprocity with Georgia—Intends to locate in Mobile.

Bill Dean Stout, M. D., University of Tennessee College of Medicine, 1958, Reciprocity with Mississippi—Intends to locate in Anniston.



Robert Benson Wilkins, M. D., University of Texas Medical Branch, 1964, Reciprocity with Texas—Intends to locate in Birmingham.



Pearl Harbor Doctor Is Only M. D. In Coosa

When the casualties from Pearl Harbor started pouring into and overflowing Tripler Hospital, the only general hospital in the Hawaiian Islands at that time, the 31-year-old officer-of-the-day was Dr. Howard Lea Cockerham, Jr., graduated only three years before with an M. D. degree from Tulane.

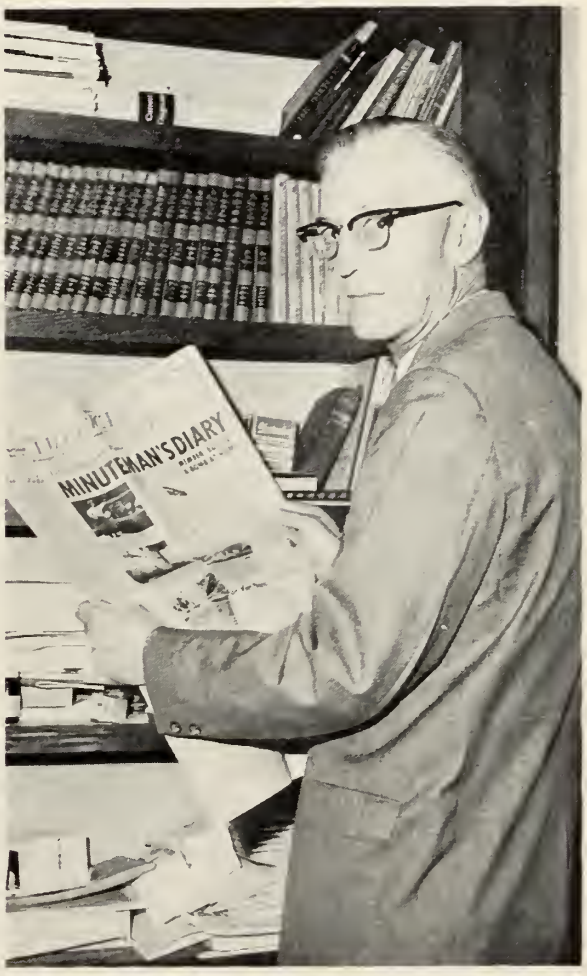
Today, three months and 27 years later, Dr. Howard Lea Cockerham, Jr., is president, vice president, secretary and treasurer of Coosa County's one-man Medical Society and, to judge from the difficulty in reaching him when he is not in surgery or on a call to an ailing patient, he is a very busy doctor indeed.

One of five children, he was born in Gunnison, Miss., on May 21st, 1911, the son of a country doctor. For his higher education, he attended Mississippi College in Clinton for three years, went on to the University of Mississippi, Oxford, for his academic degree and two years of medicine, and received his M. D. degree from Tulane.

"And how in the world did you happen to settle in Goodwater, Ala.?" he was asked.

"After five years in the army, I'd tried my luck with the Veterans Administration, with the Mississippi Board of Health as a county health officer, had stopped long enough in several towns in Mississippi and Tennessee to look the field over, and was about to set up practice in Huntsville when a group of people from Goodwater called on me. They were about to lose Coosa County's only practicing physician. I went to Goodwater in 1953 and have been there ever since."

It was while he was in the Hawaiian Islands that he met and married a Texas girl, an Army nurse. Today they have five children, which is turning full circle on the family history. For Dr. Cockerham's mother was a nurse, and five children, of whom he was one, were born to his parents.



DR. HOWARD L. COCKERHAM, JR., surgeon officer-of-the-day when the wounded from Pearl Harbor began pouring into Hawaii's only general hospital, reads a paper sent him 25 years later by a Purple Heart winner of Dec. 7, 1941. Photo courtesy of The Alexander City Outlook.

Coosa County, like the doctor who serves it, has a fascinating history extending back into the distant days before the white man came to the New World. DeSoto stopped for a week at Itaba (or Hatchett Creek), where a French census of two centuries ago showed its population was "40 warriors."

Though rich in aboriginal history, most of the Indian mounds and burials have been leveled by farmers' plows.

Distinguished Professor's Portrait Unveiled At Medical Center

"Each honest calling, each walk of life, has its own elite, its own aristocracy based on excellence of performance," the educator James Bryant Conant once wrote.

Recognition of a distinguished member of Alabama's educational aristocracy was accorded in the unveiling of the portrait of Emmett Bryan Carmichael, Ph. D., presented to the Medical College of Alabama. The excellence of his performance was recorded in a biographical sketch presented at the same time by Edwin G. Waldrop, M. D.

Dr. Carmichael's career as a faculty member of the University of Alabama has spanned seven University presidents, seven deans of the Medical College, and two vice presidents. He was assistant professor of biochemistry at this institution for a year, associate professor for four years, and full professor for 34 years. He was assistant dean of the Medical College for eight years, editor of The Alabama Journal of Medical Sciences for five years, and is now professor emeritus of biochemistry and consultant to the editorial board of that Journal.

Born in Shelbyville, Missouri, Sept. 4, 1895, educated at the University of Colorado and the University of Cincinnati, he came to the University of Alabama in 1927. Since 1927 he has taught 2,148 medical students, 676 dental students, and 37 graduate students; has published 182 papers, and "has been engaged in organizations that have promoted science and brought world recognition to the Medical College of Alabama."

Among his many recognitions is the William C. Gorgas Award from the Medical Association of the State of Alabama. He is



Dr. E. G. Carmichael

the one and only honorary member of the Caduceus Club of the Medical College, and a member of the order of Pythagoras-Acacia Fraternity.

Calendar of Annual Meetings

Medical Association of the State of Alabama

1969, April 24-26, Carriage Inn, Huntsville

1970, April 30-May 2, Mobile

1971, April 22-24, Birmingham

1972, April 20-22, Montgomery

1973, April 18-21, Mobile

heavenly relief
for unearthly cough

Benylin®
EXPECTORANT



Each fluidounce contains: 80 mg. Benadryl® (diphenhydramine hydrochloride, Parke-Davis); 12 grains ammonium chloride; 5 grains sodium citrate; 2 grains chloroform; 1/10 grain menthol; and 5% alcohol.

An antitussive and expectorant for control of coughs due to colds or of allergic origin, BENYLIN EXPECTORANT is the leading cough preparation of its kind. BENYLIN EXPECTORANT tends to inhibit cough reflex... soothes irritated throat membranes. And its not-too-sweet, pleasant raspberry flavor makes BENYLIN EXPECTORANT easy to take.

PRECAUTIONS: Persons who have become drowsy on this or other antihistamine-containing drugs, or whose tolerance is not known, should not drive vehicles or engage in other activities requiring keen response while using this preparation. Hypnotics, sedatives, or tranquilizers if used with BENYLIN EXPECTORANT should be prescribed with caution because of possible additive effect. Diphenhydramine has an atropine-like action which should be considered when prescribing BENYLIN EXPECTORANT.

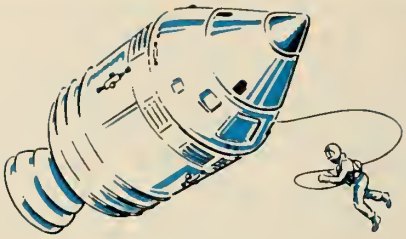
ADVERSE REACTIONS: Side reactions may affect the nervous, gastrointestinal, and cardiovascular systems. Drowsiness, dizziness, dryness of the mouth, nausea, nervousness, palpitation, and blurring of vision have been reported. Allergic reactions may occur.

PACKAGING: Bottles of 4 oz., 16 oz., and 1 gal.

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Man in space, now fait accompli, re-emphasizes the importance of Uro-Phosphate therapy. Research into the effect of space travel on the astronaut reveals that weightlessness causes loss of bone calcium. As the bones are required to bear less and less of the weight of the body they lose calcium, increasing the calcium content of the urine. When physical activity is reduced, the acidity of the urine should be adjusted to keep increased calcium in solution . . . . a prophylaxis to prevent kidney or bladder calculi.

Uro-Phosphate®

NOW A SUGAR-COATED TABLET

Each tablet contains: METHENAMINE, 300 mg.; SODIUM ACID PHOSPHATE, 500 mg.

Uro-Phosphate gives comfort and protection when inactivity causes discomfort in the urinary function. It keeps calcium in solution, preventing calculi; it maintains clear, acid, sterile urine; it encourages complete voiding and lessens frequency when residual urine is present.

Uro-Phosphate contains sodium acid phosphate, a natural urinary acidifier. This component is fortified with methenamine which is inert until it reaches the acid urinary bladder. In this environment it releases a mild antiseptic keeping the urine sterile.

Uro-Phosphate is safe for continuous use. There are no contra-indications other than acidosis. It can be given in sufficient amount to keep the urine clear, acid and sterile. A heavy sugar coating protects its potency.

Dosage:

For protection of the inactive patient 1 or 2 tablets every 4 to 6 hours is usually sufficient to keep the urine clear, acid and sterile.

2 tablets on retiring will keep residual urine acid and sterile, contributing to comfort and rest.

A clinical supply will be sent to physicians and hospitals on request.

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"The inconvenience of a cold"

o a cold, NTz® Nasal Spray provides rapid relief of
aal symptoms. Relief starts with the first spray which
pns the inferior part of the common meatus. A second
ɔly, a few minutes later, will shrink the turbinates to
e provide sinus drainage and ventilation. Dosage
n be repeated every three or four hours as needed,
r temporary relief of symptoms. NTz is well tolerated
u overdosage should be avoided.

si sinusitis deterrent, NTz Nasal Spray can be used to
eɔ the nasal passages open during a cold to help pre-
e development of acute sinusitis—or to help prevent
n acute condition from becoming chronic.

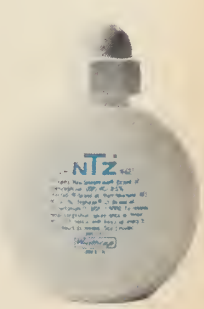
plied: NTz Nasal Spray, plastic squeeze bottles of
0ml.; NTz Nasal Solution, bottles of 30 ml. (1 fl. oz.)
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NTz is more than a simple vasoconstrictor. It contains

Neo-Synephrine® (brand of phenylephrine) HCl 0.5 per cent, the major component, virtually synonymous with fast, efficient but gentle nasal vasoconstriction.

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THE BETTMAN ARCHIVE

Just one tablet at bedtime • Prevents painful night leg cramps • Permits restful sleep

How many of your patients stamp their feet at night and lose sleep because of painful leg cramps? Unless prompted, they usually fail to report this distressing condition and suffer needlessly.

One tablet of QUINAMM at bedtime usually controls distressing night cramps and permits restful sleep with the initial dose.

Prescribing information—Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Side Effects/Precautions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

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Antrocol provides the prompt, predictable antisecretory action of the belladonna alkaloid, atropine, fortified with sedation and blended with Bensulfoid, contributing to slow, even absorption.

Each Antrocol tablet or capsule contains 0.324 mg. of atropine sulfate, which is twenty-four thousandths of a milligram more than the smallest effective dose specified in U.S.P., Vol. 17. This slight increase in the smallest effective dose of the antisecretory factor (atropine) is all the average patient can tolerate without discomfort.

One Antrocol tablet or capsule taken three times daily lessens emotional stress and maintains a gastric function that is not conducive to the development of peptic ulcer.

Antrocol is also useful in the treatment of peptic ulcer. Dosage up to 8 tablets or capsules per day to obtain the desired antisecretory titer. When ulcer has healed, one Antrocol tablet or capsule morning and evening gives protection against recurrence.

Each tablet or capsule contains:

Atropine Sulfate	0.324 mg.
Phenobarbital (may be habit forming)	16 mg.
Bensulfoid, see white section P.D.R.	65 mg.

Side-effects: Toxic levels of atropine may produce flushing, dry mouth, blurred vision, tachycardia, or urinary retention. Precautions: Do not use in glaucoma. Use cautiously in prostatic hypertrophy.

Federal law prohibits dispensing without prescription.

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Antrocol®

ANTISECRETORY SEDATIVE

MASA To Present Four Award Winners At April Meeting

A prominent editor-publisher, a Mobile television production manager, a division chief in the Health Department, and a 42-year-old general practitioner are winners of four awards of the Medical Association of the State of Alabama, and will be presented at the annual meeting next month.

Barrett C. Shelton, Sr., for 45 years editor and publisher of *The Decatur Daily*, and one of Alabama's distinguished lay leaders, will be the 10th recipient of the William Crawford Gorgas Award, given annually in recognition of a major contribution "to the advancement of good health." Mr. Shelton is currently president of the Tri-County Appalachian Regional Health Planning Commission, a federal program.



Mr. Shelton

Born in Columbia, Tenn., Sept. 3, 1902, a graduate of the public school system of Decatur, Barrett Shelton was called home from his senior year at Washington and Lee University by the death of his father, to become publisher of *The Decatur Daily*. This was in 1924.

President of the Tennessee River Valley Association, chairman of the Tri-County Manpower Development Council, a past president of the Tennessee Valley Associated Chambers of Commerce, and chairman of the Board of Governors of St. Barnard's College, Cullman, Mr. Shelton is on the boards of directors of the Diabetes Trust Fund of Alabama, the Decatur Chamber of Commerce, the Decatur Country Club, and the First National Bank of Decatur. He received the honorary degree of Doctor of Letters from St. Barnard's in 1967. He is married to the former Suzanne Jones of Decatur, and they have two children and five grandchildren.

The first William Crawford Gorgas Award went to Senator Lister Hill in 1958, and last year's recipient was the late Gov. Lurleen Burns Wallace. No awards were made for 1962 and 1963, but others honored included: Marc Ray Clement, Tuscaloosa, 1959; Paul Johnston, Birmingham, 1960; Frank S. Keeler, Mobile, 1961; Frank E. Spain, Birmingham, 1964; J. S. Smolian, Birmingham, 1965; Emmett B. Carmichael, Ph. D., Birmingham, 1966; and Ed Leigh McMillian, Brewton, 1967.

In the June, 1968, issue of The Journal of the Medical Association of the State of Alabama, appeared an article titled, "Domestic Eradication of Syphilis in Alabama." One of the two bylines under it was that of Dr. W. H. Y. Smith, Director of the Bureau of Preventable Diseases. Five months later an Associated Press dispatch out of New York predicted the complete eradication of syphilis, possibly by 1972.



Dr. Smith

With this evidence of Dr. Smith's place in the van of the fight on preventable disease, supported by other monographs on the subject, the Montgomery County Medical Society nominated him for the William Henry Sanders Award. The nomination was ultimately approved.

Born in Ottawa, Canada, graduated from Ottawa Collegiate Institute in 1917 and from McGill University in 1918, he interned at Toledo Hospital, served his residency at St. Luke's Methodist Hospital, Cedar Rapids, Iowa, and was graduated from Johns Hopkins

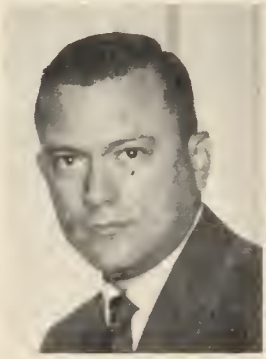
in June, 1934, with a Master's in Public Health. He transferred from the Florida to the Alabama Health Department in 1934 as director of the Venereal Disease Division and 13 years later became director of the Bureau of Preventable Diseases.

He directed the first Mass Gamma Globulin Program in Montgomery County in 1953, directed the Polio Vaccine Study in Montgomery County in 1954, and received the D. G. Gill Award in T. B. Control for 1963.

The William Henry Sanders Award is made annually to an outstanding person, "lay or professional, engaged full time in public health work, but who has performed above and beyond the call of duty."

Three earlier winners of this award are: Dr. Ira L. Myers, 1968; Dr. Otis F. Gay, 1967; and Dr. James Sidney Tarwater, 1966.

"Your Doctor," a Sunday television series on Channel 5, launched in 1963 on behalf of the Mobile County Medical Society, has won the 1969 Douglas L. Cannon Award for Production Manager Wes (Thomas W.) Diamond, of WKRG-TV. This award goes annually to commend a reporter for "accurate and factual reporting of medical news of interest to the public and for outstanding work in promoting and elevating medical news coverage."



Mr. Diamond

Born in Butler County Sept. 6, 1934, Diamond was graduated from Greenville (Ala.) High School, and in 1958 earned his B. A. degree in Radio and Television from the University of Alabama, which he attended on a W. O. Parmer Scholarship from Butler County. He has been with WKRG-TV since 1960. The Diamonds have a daughter.

In 1965, Davenport Smith and station WBRC-TV, Birmingham, received the Douglas L. Cannon Award; in 1966 it went to Anita Smith of the Birmingham News; in 1967 to Howell R. Raines of WBRC-TV; and last year to Ray Butts, WSFA-TV, Montgomery.

Dr. Aubrey E. Terry of Russellville, 1969 Chairman of the Franklin County Board of Censors, immediate past president of the Russellville Chamber of Commerce, 1966-67 president of the Russellville Civitan Club, a past director of the Boy Scouts of America, and a member of the Governor's Committee for Employment of the Handicapped, is the third annual winner of the A. H. Robins Physician Award for Community Service.



Dr. Terry

A Colbert County native, Dr. Terry entered the Navy immediately after graduation from Colbert County High School, serving in the Hospital Corps. Obtaining his B. S. and M. D. degrees from the University of Alabama, he served his residency at Lloyd Noland, Bessemer, and finished his pediatrics Board work at Johns Hopkins before beginning private practice in Russellville in 1961.

The Terrys are parents of an 11-year-old daughter.

Nominees for the A. H. Robins Award are judged, apart from their "purely professional attainments" in the practice of medicine, achievements in scientific research, development of new and useful medical and surgical techniques, and only on services that "have benefited the local or state community in a civic, cultural, or general economic sense."

There have been two previous winners of this award: Dr. Robert Parker, Montgomery, in 1967, and Dr. William C. Hannon, Mobile, 1968.

The William Crawford Gorgas Award, first presented in 1958, carries with it a plaque naming the recipient and the accomplishments that led to his selection.

The William Henry Sanders Award carries with it a plaque and an honorarium of $100.

This year the Douglas L. Cannon Award will also have a $100 honorarium in addition to the plaque. And beginning in 1970, there will be two such awards, each with its $100 honorarium.

The A. H. Robins Physician Award for Community Service has a very handsome plaque particularizing the year's selection.

Forces Of Science Unite To Fight Heart Disease

Developing guidelines to evaluate "medical facilities and services in the prevention, diagnosis, treatment and rehabilitation of patients with cardiovascular disease" is the purpose of a program recently established.

A recently established Inter-Society Commission for Heart Disease Resources, to include representatives of 26 national professional organizations and specialty boards with interest in the cardiovascular field, will carry on the study, under the aegis of the American Heart Association.

Representatives on the commission will come from the American Academies of Pediatrics, General Practice, and Physical Medicine and Rehabilitation; the American Association of Thoracic Surgery, the American Colleges of Cardiology, Chest Physicians, Physicians, and Surgeons; the American Heart Association, the American Hospital Association, the American Medical Association, Nursing Association, Psychiatric Association, and the American Thoracic Society; the Association of American Medical Colleges, the Colleges of American Pathologists and Radiology, the Joint Committee on Accreditation of Hospitals, the National League of Nursing and National Medical Association, the Society of Thoracic Surgeons, and five specialty boards: internal medicine, cardiovascular diseases, thoracic surgery, pediatric cardiology and anesthesia.

A release from the American Heart Association, serving as fiscal agent by direction of HEW, says that participating medical organizations have been appointed to the Commission "on the basis of special competence in major aspects of cardiovascular disease and expert knowledge of facilities, personnel and training programs necessary to provide the highest quality of care including prevention, diagnosis, treatment and rehabilitation of patients with cardiovascular disease."

Dr. Irving S. Wright of New York, clinical Professor of Medicine at Cornell, a past president of both the American Heart Association and the American College of Physicians, has been named National Chairman of the new commission.

Findings of the commission will be embodied in a series of published "Guidelines" available to the professions.



The Fortunate One.

Her urinary tract infection reveals itself through pain and discomfort.

While the pain and discomfort of a G.U. infection are anything but pleasant, the patient may be luckier than she realizes. That burning sensation (and/or frequency, urgency, dysuria) is a usually reliable sign of a urinary tract infection. And it's her good fortune that her infection won't go undetected...or untreated.

Azo Gantanol® therapy usually provides analgesic action within one-half hour, while control of the infection begins within two hours. Azo, a specific urinary analgesic, soothes inflamed mucosa to give symptomatic relief. At the same time, the antibacterial component, Gantanol (sulfamethoxazole), achieves therapeutic levels in the blood and urine, with diffusion into interstitial fluids. Azo Gantanol—a good choice when urinary tract infection reveals itself through symptomatic distress.

Before prescribing, please consult complete product information, a summary of which appears on opposite page.

Azo Gantanol®

(Each tablet contains 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl.)

Azo for the pain
Gantanol®
(sulfamethoxazole)
for the pathogens

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Urinary tract infections with associated pain or discomfort when due to susceptible organisms; prophylactically in urologic surgery, catheterization and instrumentation.

Contraindicated in sulfonamide-sensitive patients, pregnant females at term, premature infants, newborn infants during the first three months of life, glomerular nephritis, severe hepatitis, uremia and pyelonephritis of pregnancy with gastrointestinal disturbances.

Warnings: Use only after critical appraisal in patients with liver damage, renal damage, urinary obstruction or blood dyscrasias. If toxic or hypersensitivity reactions or blood dyscrasias occur, discontinue therapy. In closely intermittent or prolonged therapy, blood counts and liver and kidney function tests should be performed.

Precautions: Observe usual sulfonamide therapy precautions including maintenance of an adequate fluid intake. Use with caution in patients with histories of allergies and/or asthma. Patients with impaired renal function should be followed closely since renal impairment may cause excessive drug accumulation. Occasional failures may occur due to resistant microorganisms. Not effective in virus and rickettsial infections.

Adverse Reactions: Headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, skin rash, Stevens-Johnson syndrome, injection of the conjunctiva and sclera, petechiae, purpura, hematuria or crystalluria may occur, in which case the dosage should be decreased or the drug withdrawn.

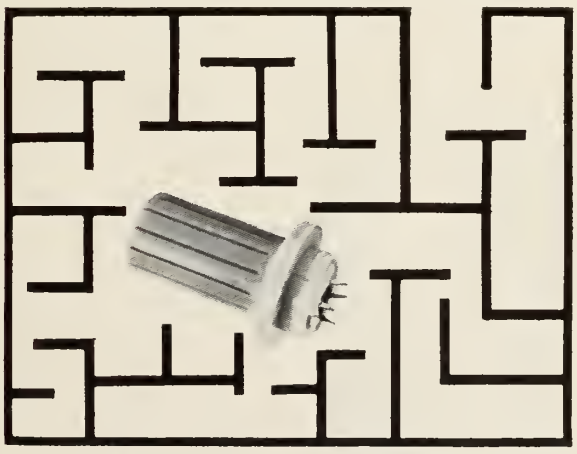
Dosage: Adults—4 tablets initially, then 2 tablets morning and evening.

How Supplied: Tablets, bottles of 50.

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LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

AMA To Step Up Malpractice Study

The AMA is increasing its efforts to help doctors who are faced with grievous problems in buying professional liability insurance. Witnesses at clinical convention hearings in Miami Beach told of reputable specialists being refused malpractice insurance in Alaska, and of the creation of a sellers' market in California by the withdrawal of a number of insurance companies from the field. The AMA House of Delegates rejected as impractical a suggestion that the AMA set up a liability insurance plan for its members. But the House called for intensified AMA studies of the problem, including legislative measures to "control or eliminate unjustified suits against physicians." The Board of Trustees was asked to report on the matter next July at the annual convention in New York City.



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Histoplasmosis can mimic such unrelated diseases as TB, leukemia, pneumonia and syphilis. Use the blue Histoplasmin LEDERTINE™ Applicator as the first step in differential diagnosis and as a routine step in physical examinations for the permanent records of your patients.

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Precautions—Nonspecific reactions are rare, but may occur. Vesiculation, ulceration or necrosis may occur at test site in highly sensitive persons. The test should be used with caution in patients known to be allergic to acacia, or to thimerosal (or other mercurial compounds).

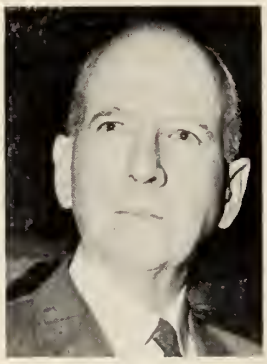
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Progress Of The Alabama Regional Medical Program

Benjamin B. Wells, M. D.*

I appreciate the opportunity to appear before this Council. The Comprehensive Health Planning Program and the Regional Medical Program have a great deal in common. In order to avoid conflict or duplication of effort, we have worked together closely from the beginning. When our Regional projects are at or near the point of completion, we submit them for review by Dr. Weathington and his staff, and these staff opinions are incorporated into our final presentations.



Dr. Wells

In the interest of your time, I shall not attempt to give a full progress report on this occasion. We have made substantial progress in planning for the Region, and we hope to enter the operational phase during the early part of this year. We have submitted twelve operational projects that are now under consideration by review authorities in Washington. Our planning material is largely in the form of explorations and surveys intended to identify health needs and health resources of the state and to invite project proposals from the local community level. In addition, we have achieved organizational, technical, and liaison arrangements that are necessary to our further progress. Frankly, these matters are rather uninteresting in their present form. I shall, of course, be happy to give you a full report of progress, after we have more concrete project descriptions to put before you.

It was my guess that you would be more interested in hearing from me just what the Alabama Regional Medical Program is, or at least what it appears to be at this point in time. I may tell you that this is not an entirely static situation. The philosophy of the program has undergone considerable "drift" since it was set in motion in the fall

*Program Coordinator, Alabama Regional Medical Program. From a report given to the Advisory Council for Comprehensive Health Planning, January 8, 1969.

of 1965, and one can safely predict that still other changes will be introduced with the further passage of time.

I think it helps a great deal to realize that all of us who are now wrestling with various elements of the health care system, regardless of the particular State, Federal, or private program that concerns us, are, in fact, responding to the same set of factors. Our responses may differ widely in their type and character, but regardless of how you look at it, we are trying to find an acceptable adaptation to the same set of circumstances.

At the beginning of the 20th century, medical services were few and they were comparatively simple. When an individual got sick, he was first treated by home remedies or patent medicines. If his illness was severe, he might be treated by the family physician, either in the home or in the physician's office. There were few hospitals and their use was quite exceptional among all groups of our population. Entirely aside from matters of cost, hospitals were generally thought of as serving one of three functions: (1) First, they were places to put people who had contagious diseases in order to protect the community from the spread of infection; (2) Second, many of them were charitable institutions designed to take care of people who were too sick to earn yet too poor to have an adequate home environment for their care; (3) Third, the hospital was too often thought of as a place where you went to die. Altogether, this is a rather dismal but accurate picture of the average hospital situation in the year 1900.

Dramatic events began to take place in the early years of this century. A large number of new departures upset and permeated the entire social, economic, and industrial structure of this country. We can safely assume that changes taking place in the character of medical practice were secondary to the rapid expansion of individual earning capacity of workers, better and more generally available education, improved communication, the technological explosion, and the many other developments that have made the first fifty years of this century one of the most remarkable periods in the history of mankind.

The entire story is not necessary for our immediate purpose. The important fact is that medical practice moved from its traditional home-and-office base to the hospital—where it has remained to this day. It is difficult to trace the steps and almost impossible to define all the reasons for this shift. The American people had more money to spend, they had more general education, they had faster means of communication, and methods of transportation that far exceeded the expectations of former years. With these new advantages went a new set of values, new buying habits, and new demands for goods and services of all kind.

This was the era for growth and recognition of American hospitals. The American Medical Association established its Council on Medical Education and Hospitals in 1904. Hospital clerkships and internships became an established part of medical education. The first list of approved residency programs was published by the AMA in 1927. The number of hospital beds increased by 280 per cent between 1909 and 1955.[1] I shall not bore you with statistical details. When people got sick, now they expected to go to a hospital. When a baby was to be born, it was expected to be born in a hospital. It is interesting to note that obstetrics was relatively slow in its move to the hospital. As late as 1935, 63 per cent of babies were born at home. This proportion dropped to 14 per cent by 1948. Now in the 1960s, births may take place in taxi cabs and elevators, but rarely are they planned to take place at home. Incidentally, Mr. John F. Kennedy is said to be our first president who was born in a hospital.

So, the hospital became and remains the institutional setting for a very large proportion of medical care. Likewise, the hospital established its role as the primary focus around which health care activities and much of our education and training in the health

care field can be most efficiently coordinated. Perhaps the most simple but meaningful expression of this relationship is that patients are now largely taken care of in hospitals; therefore, the hospital is the logical hub of the health care industry.

This story would not be complete without noting two subsequent developments that have important bearing on the delivery of modern health services. The first of these was the rise of the medical center. Although there were earlier groups serving a similar purpose, the first medical center to be designated as such was the Columbia-Presbyterian Medical Center.[2] This combination of schools, hospitals, and clinics was opened in 1928. The concept of the medical center did not really take hold, however, until sometime during or directly after World War II. There is no doubt that the circumstances of war, the rapid development of new and costly technologies in medicine, and the shortage of specialized personnel had a great deal to do with stimulating their development. Although no one has precisely defined a medical center, it is generally agreed to be a grouping of institutions and of professional skills in a single locality in order to provide a full spectrum of medical care—which means care for patients of all ages, with all kinds of diseases or health needs, inpatients, outpatients, and so on. In any event, we have arrived at the "age of medical centers" just as certainly as we have adopted the supermarket and the suburban shopping center. Since this particular development is still going on, we are too close to evaluate its full impact or to predict its future.

Finally, we find ourselves in the midst of still another organization for the delivery of health services. This latest one is called the Regional Medical Program. Regionalization of health resources is not a new or recent idea. Its history can be traced back for at least 35 years in this country. The most aggressive attempt to establish the principle of regionalization in our time was contained in the provisions of the original Hill-Burton Act of 1946. The concept of a medical region is poorly understood by all of us. We simply must wait for experience and historical perspective before we can make a final judgment.

Perhaps we can approximate a definition by saying that a medical region is a cooperating group of medical facilities and professional personnel designed to deliver a full spectrum of health care to a relatively large geographic and population sector. As I see it, the medical region is unique in that it assumes a much broader cooperation between health care resources, and in that it must have the active participation of essentially all elements of the body politic; specifically, it must involve both the providers and the consumers of health services. An exceedingly important addendum to the regional con-

(Continued on Page 857)





Nose clear as a whistle

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Dimetapp Extentabs® does an outstanding job of helping to clear up the stuffiness, drip and congestion of colds and upper respiratory allergies and infections. Each Extentab keeps working up to 12 hours. And for most patients drowsiness or overstimulation is unlikely. Try Dimetapp. It clearly works.

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Dimetane® (brompheniramine maleate), 12 mg.; phenylephrine HCl, 15 mg.; phenylpropanolamine HCl, 15 mg.

UP TO 12 HOURS CLEAR BREATHING ON ONE TABLET

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Contraindications: Hypersensitivity to antihistamines. Not recommended for use during pregnancy.
Precautions: Until patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension.
Side Effects: Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia, have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered.
Dosage: 1 Extentab morning and evening.
Supplied: Bottles of 100 and 500.

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A·H·ROBINS



Owner Breaks Arm When Yacht Runs Aground

Schuyler, Oct. 31. Harry Waters of Covesville incurred a fractured arm [illegible] acht [illegible] ck a large rock tially capsized. The fire depart had to rescue Waters by small Damage to the yacht is estimat

Hasn't the skipper had enough excitement for one day?

For the patient who has been through an accident, the worry and anxiety following the mishap may actually heighten the perception of pain. This is why there's a classic ¼ grain *sedative* dose of phenobarbital in Phenaphen with Codeine—to take the nervous "edge" off, so the rest of the formula can control the pain more effectively.

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Phenaphen® with Codeine

Phenaphen with Codeine Nos. 2, 3, or 4 contains: Phenobarbital (¼ gr.), 16.2 mg. (warning: may be habit forming); Aspirin (2½ gr.), 162.0 mg.; Phenacetin (3 gr.), 194.0 mg.; Hyoscyamine sulfate, 0.031 mg.; Codeine Phosphate, ¼ gr. (No. 2), ½ gr. (No. 3), or 1 gr. (No. 4) (warning: may be habit forming).

The compound analgesic that calms instead of caffeinates

Indications: Phenaphen with Codeine provides relief in severer grades of pain, on low codeine dosage, with minimal possibility of side effects. Its use frequently makes unnecessary the use of addicting narcotics. **Contraindications:** Hypersensitivity to any of the components. **Precautions:** As with all phenacetin-containing products excessive or prolonged use should be avoided. **Side effects:** Side effects are uncommon, although nausea, constipation and drowsiness may occur. **Dosage:** Phenaphen No. 2 and No. 3—1 or 2 capsules every 3 to 4 hours as needed; Phenaphen No. 4—1 capsule every 3 to 4 hours as needed. For further details see product literature.



(Continued from Page 854)

cept is the fact that it proposes to accomplish this coordination at the local level, and in so doing to assure the best quality and quantity of medical services to all citizens everywhere. We must add the further fact that all this inter-institutional and inter-group cooperation, sharing of resources, and so on is expected to take place on an entirely voluntary basis.

Here we have a concept so heavily charged with benevolence that I feel positively unclean when I suggest that there are many questions to be answered. Although there are benefits and efficiences that can be accomplished through regionalization, it would be an error, in my opinion, to say that the concept has been generally accepted or that it should be immediately and totally implemented.

In support of new movements, it has become a popular exercise to point out and emphasize the weaknesses of American medicine. The critics and alarmists neglect to say, however, that these weaknesses are conspicuous because they are seen against the background of the largest, most technically advanced, the best educated, and, admittedly, the most costly medical service in the history of the world. (The same things can be said, by the way, of our automobile industry, telephone system, and any number of other national enterprises.) American medicine is painfully aware of its own relative shortcomings. During the past few years, organized medicine has engaged in a veritable orgy of soul searching and self analysis. Advice and counsel has been sought from practically every non-medical sector of American life by frustrated physicians who are far more anxious to please their patients than to retain the tattered fragments of their self-esteem. American medicine has given its full support to the Regional Medical Program and to the Comprehensive Health Planning programs, along with many other pieces of progressive social legislation. All we are asked to do, I believe, is to offer our changes in the light of existing realities, and not to "throw out the baby with the bath water."

With these thoughts in mind, we have submitted our first set of operational projects for the Alabama Regional Medical Program. Within the limits of funds made available to us, we shall decentralize activities to the local levels in the State. We have tried to identify local needs, judge their relative priorities and mobilize local ideas for the fulfillment of recognized deficiencies. Our initial objectives are directed primarily toward continuing education for the entire health service team and the development of allied health service personnel that are in extremely short supply in this State. We know that these are relatively limited goals, but we see them as logical points of departure. When we have demonstrated our ability to move in these directions, there will be plenty of time to raise our horizons.

Before arriving at any specific projects, we have gone through a rather intricate process of evolving a planning matrix or framework for the entire Region. This began with a decision to use the seven geographic divisions of the State that have long served the purpose of planning for hospital facilities. Then, we have sought to identify the health needs, health facilities, manpower resources, and unique features of each sub-Region or Area. We have given particular attention to *opportunities* that exist in each Area for inter-institutional or inter-group cooperation, for special projects that may contribute to the total Region, and for the use of existing local people and activities that may be turned to quicker gains by project support.

In every instance we have emphasized the importance of Regional objectives, with or without formal projects and operational funds. We have encouraged and offered staff assistance, when we could, to those who were ready and able to find local funds or non-RMP funds to solve their local health care problems.

We have recognized the fact that certain

(Continued on Page 860)

So he'll breathe easier:

relieve anxiety while you relieve pain.

Relief of pain is usually a major goal in traumatic conditions. But often of importance, too, is alleviation of anxiety and tension that may heighten patient discomfort.

Single-prescription, non-narcotic Equagesic may effectively relieve pain. *And* ease anxiety and tension.

TABLETS

Equagesic®

(meprobamate and ethoheptazine citrate with aspirin) Wyeth®

IN BRIEF.

Contraindications: History of sensitivity or severe intolerance to aspirin, meprobamate or ethoheptazine citrate.

Warnings: USE IN PREGNANCY: Safety for use during pregnancy or lactation has not been established; therefore, it should be used in pregnant patients or women of child-bearing age only when the physician judges its use essential to the patient's welfare.

Precautions: Keep out of reach of children. Not recommended for patients 12 years old or less. Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use of meprobamate in susceptible persons—as alcoholics, ex-addicts, severe psychoneurotics—has resulted in dependence or habituation. Withdraw gradually after prolonged excessive dosage to avoid possibly severe withdrawal reactions including epileptiform seizures. Warn patients of possible reduced alcohol tolerance, with resultant slowed reactions and impaired judgment and coordination. If drowsiness, ataxia or visual disturbances (impairment of accommodation and visual acuity) occur, reduce dose. If symptoms persist, patients should not operate machinery or drive. After meprobamate overdose, prompt sleep, reduction of blood pressure, pulse and respiratory rates to basal levels, and hyperventilation are reported. Give cautiously and in small amounts to patients with suicidal tendencies. Treat attempted suicide (has resulted in coma, shock, vasomotor and respiratory collapse and anuria) with gastric lavage and appropriate symptomatic therapy (CNS stimulants and pressor amines as indicated). Two instances of accidental or intentional significant overdosage with ethoheptazine and aspirin have been reported. These were accompanied by CNS depression (drowsiness and lightheadedness) but resulted in uneventful recovery. On basis of pharmacologic data, CNS stimulation could be anticipated, with nausea, vomiting and salicylate intoxication (requires induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, and observation for hypoprothrombinemic hemorrhage [usually requires whole blood transfusions]).

Adverse Reactions: Ethoheptazine and aspirin may cause nausea with or without vomiting and epigastric distress, in a small percentage of patients. Dizziness is rare at recommended dosage. Meprobamate may cause drowsiness, ataxia and rarely allergic or idiosyncratic reactions. These reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses. Such patients may have had no previous contact with meprobamate and may or may not have an allergic history. Mild reactions are characterized by urticarial or erythematous maculopapular rash. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. If allergic reaction occurs, discontinue meprobamate; do not reinstitute. Severe reactions, observed very rarely, include fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. These cases should be treated symptomatically including, when indicated, such medication as epinephrine, antihistamine and possibly hydrocortisone. A few cases of leukopenia, usually transient, have been reported on continuous use. Rarely, aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia have been reported, almost always in presence of known toxic agents.

Overdosage: See precautions section for management of overdosage.

Composition: 150 mg. meprobamate, 75 mg. ethoheptazine citrate and 250 mg. aspirin per tablet.

Wyeth Laboratories Philadelphia, Pa.

Photo professionally posed.





(Continued from Page 857)

types of activity will necessarily have to originate at the Medical Center in Birmingham, but we have always reaffirmed the principle of decentralization within the State. One of our ultimate objectives is to establish a teaching and demonstration unit in at least one major hospital in each of the six peripheral Areas. These "islands of excellence" are intended to carry to the local practicing physicians the advantages that are presently so largely concentrated at the Medical Center.

In our work with the sub-Regional Areas we have not lost sight of our purpose to achieve an equitable distribution of activities in relation to geography, population, demonstrated needs, resources, and so on. In all candor, however, we find ourselves under the pressure of time and circumstance often tending to select the expedient and attainable objective. Among other things, the planning matrix will serve as a constant reminder of the total scope of our responsibilities.

In my opinion, the most important accomplishments of the planning effort to date are not the projects that have been developed but the widespread and animated dialogue that has been generated between and among the many relatively isolated elements of the health service system in Alabama.

The Regional Medical Program is not visualized as a source of funds for the solution of health care problems, but as a mechanism to facilitate solutions through coordination and cooperation between existing elements of the health care system, by improved methods of communication and continuing education, and by programs and projects that will tend to maximize the use and benefit of those resources that we already have. Admittedly this is a difficult assignment, the nuances of which will be missed or obscured by restive and impatient groups who have lost faith in our voluntary free-enterprise system, or by those who are beguiled by the prospect of "free money" from afar.

Throughout our planning efforts we have enjoyed the full support and cooperation of the Medical Association of the State of Alabama, and the State Health Department and its various divisions. We have excellent working relationships with the Alabama Hospital Association and the several hospital councils of the State. Our program has been the subject of state-wide discussions with the Alabama Nurses Association and the Alabama League for Nursing; both organizations have voted us their full support and cooperation. The Alabama Heart Association and the Alabama Division of the American Cancer Society have worked with us from the beginning, as has the Alabama Diabetes Association. We have enjoyed extremely productive relationships with the state office of Comprehensive Health Planning and with the Appalachian Regional Commission. Valuable contributions have been made to our planning efforts by many County Medical Society groups, and by a large number of individual hospitals through their professional and administrative staffs.

In the final analysis, those of us who devote our full time to the Regional Medical Program must accept the responsibility of interpreting the public will under the guidance of our Regional Advisory Group. It is obvious that choices must be made and priorities established. This is a labor of inevitable imperfection, since our funds are small and the potential needs are almost limitless. I can only tell you that we have devoted much time and effort to the construction of decision-making and priority-setting mechanisms which we and our advisors believe to be equitable and calculated to serve the best interest of the people of Alabama within the legal framework set for us by Public Law 89-239.

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1. "How American Buying Habits Change." U. S. Dept. of Labor, U. S. Govt. Printing Off., 1959.

2. "Present-Day Medical Education and the Medical-Center Concept." H. Houston Merritt, M. D., The New Eng. J. of Med. 271: 1194-1197, Dec. 3, 1964.

Crisis In Alabama's Ambulance Services Approaches Fast

"Our military forces are one team—in the game to win regardless of who carries the ball," General Omar Bradley told a House armed services committee hearing in 1949.

Whether in war or peace, soldiers or civilians, at play or at work, in business or in the professions, and particularly where the stakes are life and death, every member of the team has a role.

Accidents and illnesses are the concern of medical teams, and every position on the team can be vital to the survival of someone. In emergencies, very often every other member of the life-saving team is found waiting for the ambulance.

Too often in Alabama that wait is in vain.

At the direction of Dr. Ira L. Myers, the State Health Department has been conducting a statewide survey on ambulance services, in support of a bill now being prepared to coordinate and regulate emergency medical services in the state. Presently there is only permissive state legislation for ambulance operation; only three communities have legislation regarding ambulance service, and these are recent.

In these 83 ambulance services in the 43 counties surveyed, there are 35 commercial firms, 33 services operated by funeral homes, three professional (2 police, one fire department), and 6 other odd types.

The National Highway Safety Act of 1966, enacted by Congress, provides "that each state shall have a program to ensure that persons involved in highway accidents receive prompt emergency medical care under the range of emergency conditions encountered," and it continues: "The program shall provide, as a minimum, that there are training, licensing, and related requirements for ambulance and rescue vehicle operators, attendants, drivers, and dispatchers."

Fifty-two of the 83 companies operated at a loss the last fiscal year, 21 reported their business broke even, and only 10 showed a profit. In some cities ambulances are going beyond the city limits and in one they are serving an adjoining county also.

The National Highway Safety Manual puts a minimum annual revenue at $30,000 for annual revenue to man and operate one ambulance vehicle on a 24-hour, 7-day-a-week basis.

Effective subsidies are suggested as the only way to provide adequate ambulance service in the state, and pending legislation would put responsibility for such service on the shoulders of the State Health Department.

Out of the survey came the following specific recommendations:

1. To introduce legislation which would designate a proper authority with powers to set rules and regulations for Emergency Medical Services.

2. To standardize emergency vehicles with adequate equipment to render emergency care to the ill and injured.

3. To provide training for those persons involved in emergency medical services.

4. To sponsor statewide radio communications for ambulances, hospitals and doctors.

5. To sponsor community education for emergency situations. This would include proper individual identification so that immediate treatment could be given. It would include emergency medical telephone numbers enlarged in the front of city phone books. It would include changing the name ambulance operator to that of paramedical corps. It would also encourage payment of all ambulance fees.

6. To discuss with cities their emergency situations and the best ways to utilize every possible service for the good of all.

7. To provide inspection services and licensing of vehicles.

nursing care for cancer patients–

...a major concern for their families, *and* for their physicians. In a unique pioneering service, the American Cancer Society is deeply involved in finding a solution.

Recognizing the phenomenal growth of nursing homes—aware of the shortage of nurses—knowing the implications of the extended care benefits of Medicare—the Society has launched a dramatic educational demonstration project on cancer nursing for nursing home staff. Special emphasis is on colostomy irrigation, care of the laryngectomized patient, care of an ileal bladder, and emergency nursing. To achieve maximum application of this plan, a cadre of nurses is being trained by the Society to conduct cancer nursing courses in nursing homes throughout the nation.

This endeavor has been warmly endorsed by the American Nurses Association and other professional organizations. We feel sure that such a program, bringing skilled nursing care to the bedside of the cancer patient, will be enthusiastically received by the medical profession.

AMERICAN CANCER SOCIETY®



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MEETINGS • *Four day scientific sessions focused on family practice presented by recognized authorities.*

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One day in St. Thomas, Virgin Islands, with a drive of Charlotte Amalie (capital) and its environs reveals breathtaking views of the blue sea and sky while visiting historic Bluebeard's Castle, Drakes Channel, Mountain Top Hotel, Fort Christian and French Town. Also 102 boutiques and shops filled with incredible bargains.

You may bring back $200 per person in duty-free purchases from St. Thomas.

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Every evening at sea, special parties have been planned for you by the Alabama Academy of General Practice, and are part of your all-inclusive cruise cost. Dancing and top entertainment fill out an around-the-clock schedule of carefree fun!

RESERVATIONS • *Limited space. First Come, first served. First-class cabins with private bath begin with $264 up to $434, including all gratuities, meals, port taxes, deck chairs, cocktail parties, and shore excursions.*

For full details and reservations write: Alabama Academy of General Practice, 88 West South Boulevard, Montgomery, Alabama 36105.

ABOARD THE LUXURIOUS M/S BOHEME - LEAVING MIAMI MAY 3, 1969 FOR 7 DAYS.



The Month in Washington

From the Washington Office
American Medical Association

Washington, D. C.—A Federal Communications Commission proposal to ban cigarette advertising on radio and television put the issue squarely before Congress again.

In 1965, Congress outlawed any federal or state controls on cigarette ads as a provision of the legislation that made mandatory that cigarette packages carry the warning: "Caution: Cigarette Smoking May be Hazardous to Your Health." Proponents of the electronic advertising ban contend that the package warning doesn't make enough impact.

Even before the FCC announcement, some members of Congress were saying that the provision outlawing federal and state controls over cigarette advertising should be allowed to expire on June 3. However, congressional reaction to the FCC ruling was mixed.

The American Medical Association House of Delegates, at its meeting in Miami Beach last December, declined to approve a resolution condemning cigarette advertising on TV. Instead, it adopted a resolution urging that AMA members "play a major role against cigarette smoking by personal example and by advice regarding the health hazards of smoking." The adopted resolution also made it Association policy that the AMA "discourage smoking by means of public pronouncements and educational programs" and "take a strong stand against smoking by every means at its command."

Anticipating censorship charges—which came promptly from the tobacco and broadcasting industries, and some members of Congress, the FCC said in announcing its proposal:

"We believe that in the case of such a threat to public health, the authority to act is really a duty to act. We stress again that our action is limited to the unique situation and product; that we are unaware of any other product commercials calling for such action, and expressly disclaim any intention to so proceed against other product commercials."

* * *

A nationwide increase in deaths from pneumonia was attributable to the Hong Kong flu epidemic, the federal government reported.

"Pneumonia-influenza deaths increased over what was expected normally over the time the flu epidemic was active," Public Health Service Surgeon General Dr. William H. Stewart said, adding the deaths included all kinds of pneumonia and that the increase was "almost universal across the country."

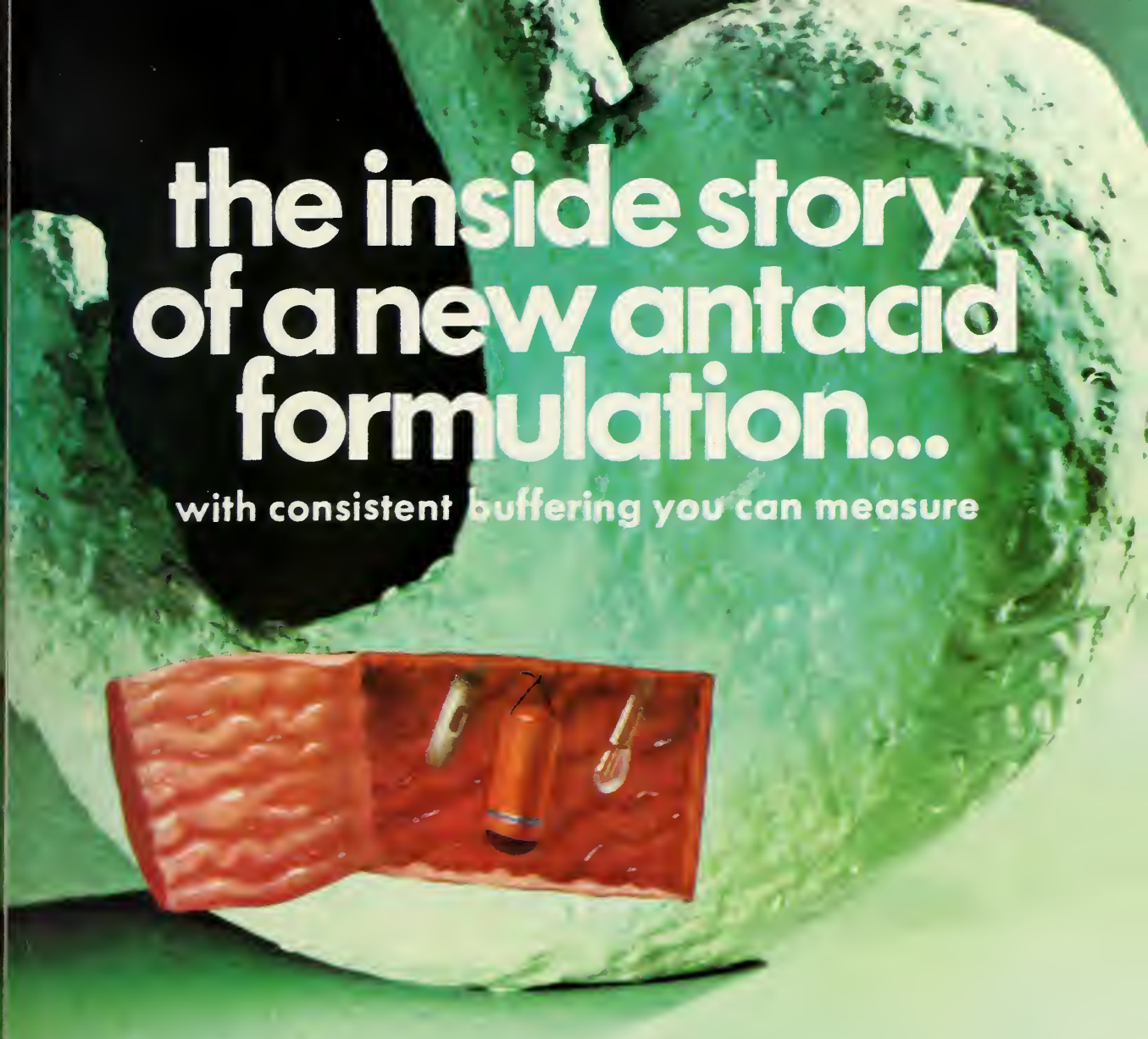
The National Communicable Disease Center in Atlanta said pneumonia-influenza deaths are one measurement of the severity of a flu epidemic. Reports from 122 cities during the eight weeks ended February 1 show 5,270 more pneumonia-influenza deaths than the number normally predictable during that period. The epidemic then was "on a downtrend," according to the CDC.

* * *

Robert H. Finch, the new secretary of Health, Education and Welfare, is giving health care costs a high priority in tackling the department's problems.

Even before he was sworn in as secretary, Finch made an unannounced call on chairman Wilbur D. Mills (D., Ark.) of the House Ways and Means Committee, which has jurisdiction over HEW's medicare and medicaid

(Continued on Page 867)



consistently scored high in degree and duration of intragastric buffering

Employing aspiration of gastric juice, indwelling electrode, and/or Heidelberg telemetering capsule techniques,* studies involving 79 subjects with or without proven peptic ulcer disease compared intragastric buffering capacity of Gelusil-M and 1 or the other or both of 2 leading ethical antacids, using comparable doses.*

All three antacids raised the pH above 3.5, an accepted criterion for antacids. The amount of time above this pH helps to characterize the buffering activity of an antacid. While it is not implied that a direct therapeutic correlation exists, these techniques do, however, objectively demonstrate the buffering characteristics of this new antacid in terms of onset of action, peak pH, duration of buffering action.

Mean peak pH*

Gelusil-M, mean peak pH 6.6 (range: 5.6-7.8).
Antacid A, mean peak pH 5.5 (range: 4.2-7.5).
Antacid B, mean peak pH 5.5 (range: 4.4-6.3).

Mean duration of buffering action above pH 3.5*

Gelusil-M, 29.8 mean minutes (range: 18.0-51.8 minutes).
Antacid A, 24.6 mean minutes (range: 6.3-48.0 minutes).
Antacid B, 23.3 mean minutes (range: 5.9-50.0 minutes).

Mean duration of buffering action above pH 5.0*

Gelusil-M, 23.2 mean minutes (range: 14.3-43.9 minutes).
Antacid A, 10.1 mean minutes (range: 6.7-12.2 minutes).
Antacid B, 16.3 mean minutes (range: 8.0-24.2 minutes).

Onset of action*

In speed of intragastric buffering action, Gelusil-M, Antacid A, and Antacid B were consistently rapid and not measurably different.

*References: Antacid studies, data on file, Warner-Chilcatt Labarataries Divisian.

introducing new GELUSIL®-M

each 5 ml. teaspoanful contains:
500 mg. magnesium trisilicate, 250 mg. aluminum hydraxide (Warner-Chilcott), 200 mg. magnesium hydroxide
U.S. Patent No. 3,326,755

a consistent buffering anticostive† antacid

† Avoids constipotion.

See next page for prescribing informatian ►

GELUSIL–one name to remember...and a dosage form for every patient.



Gelusil®-M Liquid

especially for the constipation-prone patient

Indications: Gelusil-M is indicated for prompt and dependable symptomatic relief of peptic ulcer, gastritis, heartburn, hiatal hernia, esophagitis, and other conditions for which control of gastric hyperacidity is required.

Precaution: Prolonged or intensive therapy in patients with severe renal insufficiency may lead to hypermagnesemia.

Dosage: One to two teaspoonfuls (5 ml. to 10 ml.) between meals and at bedtime or whenever symptoms occur. Certain conditions, such as acute peptic ulcer, may require individualized dosage. If diarrhea occurs, reduce dosage or discontinue use.

Supplied: Gelusil-M (spearmint-flavored)—light green bottles of 12 fl. oz.; and a **special hospital pack**. Keep tightly closed—shake vigorously.

Gelusil® Tablets

the universal take-along antacid

Easy to take along / easy to take / pleasantly mint-flavored. An antacid with adsorbent and demulcent properties which contains in one tablet: 0.25 Gm. aluminum hydroxide (Warner-Chilcott) and 0.5 Gm. magnesium trisilicate (USP).

Dosage: 2 tablets—or more—between meals and at bedtime, or whenever symptoms occur. Tablets should be chewed.

Regular Gelusil® Liquid

when constipation is not a problem

Pleasant mint flavor...ideal for hospital or home. Available in 12 fl. oz. and 6 fl. oz. bottles and a special hospital pack. An antacid which contains adsorbent and demulcent agents in each 4 ml. teaspoonful: 0.25 Gm. aluminum hydroxide (Warner-Chilcott), 0.5 Gm. magnesium trisilicate (USP).

Dosage: 2 teaspoonfuls (4 ml. each)—or more—between meals and at bedtime, or whenever symptoms occur.

Also Available: Gelusil® Flavor-Pack, Gelusil-Lac®.

WARNER-CHILCOTT
Morris Plains, New Jersey
GM-IN-93-4C

(Continued from Page 864)

programs. Finch afterwards said his staff would confer with Mills' staff to consider legislation or regulations that could combat higher health care costs.

"His staff and my people are going into this to see what we can do about the skyrocketing costs—especially hospitalization where 70 per cent of the costs are labor," Finch said.

The former California lieutenant governor said he was thinking about the pilot program in his native state—which he called a paramedical program—whereby long stays in the hospitals are shortened by putting people in intensive care centers. If hospital stays could be shortened, he said, "massive savings would result."

Mills was reported as favoring broadened medicare benefits or hospital care to cover disabled workers, who, by nature of their disabilities, receive Social Security payments —but because they are under 65—are ineligible for medicare. He also was reported to be concerned over increases in hospital charges and doctors' fees.

Several members of Congress have expressed concern over increases in the federal costs of medicare and medicaid. The Johnson Administration's budget for fiscal 1970, starting next July 1, allots $6.9 billion, up $636 million, for medicare and $3 billion, up $600 million, for medicaid.

A bill, introduced by Sen. George Aiken (R., Vt.), with Senate Majority leader Mike Mansfield (D., Mont.) and Sen. Winston Prouty (R., Vt.), as co-authors, would do away with the present "usual and customary charge concept," place all physicians on assignment, and reimburse them through the average payment for the same service provided by the local Blue Shield. Deductibles and co-insurance would be eliminated, among many other changes.

The Labor Department reported that medical costs, including both hospitalization and physicians' fees, rose 7.3 per cent for the calendar year 1968.

Finch said the Nixon Administration's HEW budget requests would be about the same size as the $17.5 billion submitted by the Johnson administration, but that there would be changes within the overall total. Estimated total federal spending in the health field will rise to $18.3 billion.

HEW said that national spending for health care, both government and private, continued to rise in fiscal 1968. The total for 1968 was $53.1 billion, $33.7 billion private and $19.4 billion government. This compared with $47.9 billion ($32.2 billion private and $15.7 government) for fiscal 1967. In fiscal 1960, it was $26.4 billion—$20 billion private and $6.4 billion government.

* * *

The Defense Department will call up 437 physicians, 23 osteopaths and 25 optometrists in 1969 in the lowest doctors draft in seven years. The total of 485 medical men compared with 1,126 drafted in 1968, 2,329 in 1967, 2,596 in 1966 and 2,830 in 1965.

The stabilization of the buildup of forces associated with the Vietnam war and with a large number of volunteers made it possible to keep the doctors draft low, the Pentagon said. All of the physicians will go into the Army. Some of the osteopaths and optometrists will go into other services. None will go into uniform until July.

The National Research Council charged that most ambulances in the U. S. are not "providing emergency care to the critically injured." It cited a lack of equipment, supplies and untrained attendants.

The Council said that "hearses and station wagons, commonly used as emergency vehicles," do not carry the necessary equipment or provide the space for such equipment "for the carrying out of modern resuscitative procedures either at the scene of an accident or during transportation." It said "action

(Continued on Page 869)

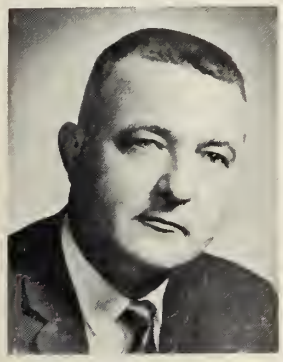


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To Every Doctor in Alabama Concerned for the Future of His Profession

As your new Chairman of Alabama's Medical Political Action Committee, I want to take this opportunity to pledge my most sincere efforts to creating a favorable legislative atmosphere, in Montgomery as well as in Washington, which will prove of great benefit to every doctor in this State.



Dr. Murchison

My colleagues on the ALAPAC board, one representing each congressional district and the Woman's Auxiliary, have accepted the responsibility entrusted to us with full knowledge that we cannot do a job without your help.

I urge each of my fellow physicians to reflect carefully whether he and his wife are doing all that they can do to protect our honored profession from socialization and bureaucratic domination. It is extremely important that doctors all over our State become active politically for the free practice of medicine, regardless of party affiliation.

Our immediate objective is to bring Alabama doctors to a keener awareness of the way ahead. Our legislative representatives, both state and national, need and want our support and help. Only through such an organization as ALAPAC can they get it.

More than 25% of the membership of the Medical Association of the State of Alabama supported ALAPAC in 1968. Our goal is to double this number in 1969.

For the small sum of $35, you and your wife can become members of ALAPAC for 1969. Of this amount $10 is forwarded to AMPAC for **your** annual membership in that organization, and for an additional $10 your wife may also join AMPAC.

Mail your contribution today to Post Office Box 6006, Montgomery, Ala. 36106, and get on the first line of defense for Medicine in Alabama.

G C Murchison Jr., M.D.

Grover C. Murchison, Jr., M. D.
ALAPAC Chairman

THE MONTH IN WASHINGTON

(Continued from Page 867)

must be taken to develop and enforce nationwide standards for ambulance service," because accidental injuries are the leading cause of death during the first half of a person's life span.

"Only 10 states have statutes prescribing the equipment to be carried by an ambulance, and the federal guidelines for motor safety do not cover the special features necessary to safe transport of the critically ill or injured," the council reported.

The National Research Council is a subsidiary of the National Academy of Sciences, an organization created by a congressional charter in 1863.

52 Package Disaster Hospitals Dot State And Await SOS

A nuclear blast may never come to Alabama. But if it should, it is reassuring to know that 200-bed hospitals will spring up all over the state of Alabama, where no hospitals were before. Fifty-two of them, by today's count!

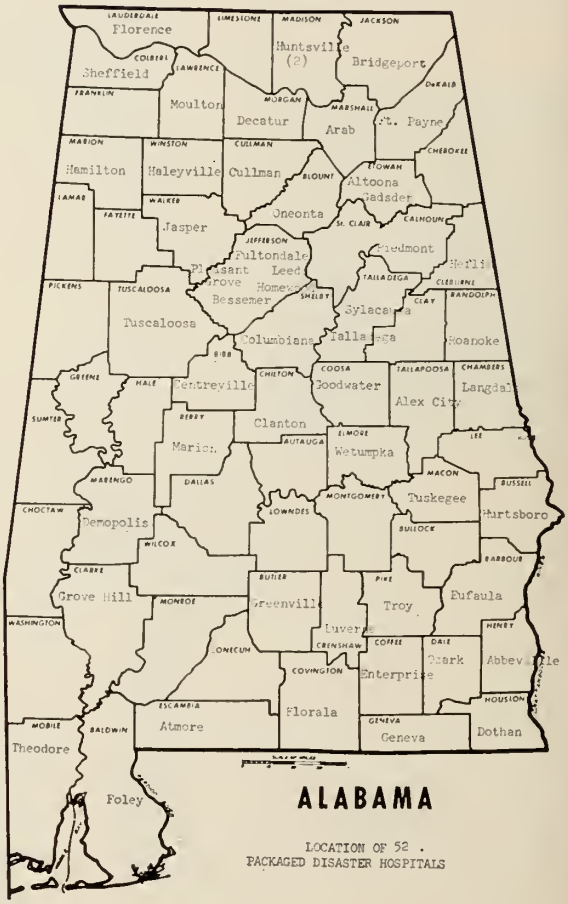
And meantime, if a major emergency—such as a hurricane, a series of tornados, or a disease epidemic—should overtax the capacity of hospitals in any part of the state, the PDH (or Package Disaster Hospital) is ready to be unpacked immediately.

These hospitals are brand new, in that none of the equipment, furnishings, power plants or instruments is war surplus.

But they are not ordinary hospitals. Everything is designed for fast assembly and the operation is keyed to speed and, where it does not interfere with efficiency, to economy. The generator may be operated by available power or the equipment is there to generate its own. The beds are army-type cots. The X-ray machine is poloroid, to obtain immediate pictures. There is a complete operating room and also a fully furnished dental office. The PDH is stockpiled with medicines under their generic names rather than their trade names.

Each 200-bed hospital unit is packed in boxes, stored in an air-conditioned area of 7,530 feet, ready to be set up in a preselected building when disaster strikes, capable of operating 30 days without resupply. And the value of each unit is $45,000, which means that the total cost of the 51 Alabama units approximates $2.29 million.

These hospitals were originally distributed and located by the Civil Defense organization, but today, in Alabama, they are the responsibility of the State Health Department and the administrators of individual hospitals in the area, wherever agreements have been worked out, are assuming charge of them.



Calendar of Annual Meetings

Medical Association of the State of Alabama

1969, April 24-26, Carriage Inn, Huntsville

1970, April 30-May 2, Mobile

1971, April 22-24, Birmingham

1972, April 20-22, Montgomery

1973, April 18-21, Mobile



WHAT A PDH CONTAINS:—From top left: Admitting and Sorting Section, Ward Section, Operating room; from top right: X-ray Section, Laboratory, Water and Power Section. . . . See article on opposite page.

LABORATORIES

Thomas S. Hosty, Ph. D., Director

Alabama Department of Public Health
Laboratory Combined Division Report for Period

January 1969

	No. Specimens received
General Bacteriology	1,764
Virology	197
Parasitology	1,753
Enteric Bacteriology	238
Fluorescent Microscopy	5,945
Tuberculosis	5,236
Mycology	47
Milk and Dairy Products	5,717
Water	3,152
Sea Foods	112
Syphilis Serology	32,325
Special Serology	1,448
Metabolic Diseases	7,424
Cytology	2,960
Chemistries	299
Miscellaneous	936
Total Number of Specimens Received	69,553

BUREAU OF PREVENTABLE DISEASES

W. H. Y. Smith, M. D., Director

Current Morbidity Statistics

1969

	Dec.	Jan.	*E. E. Jan.
Tuberculosis	77	101	107
Syphilis	47	52	115
Gonorrhea	384	388	346
Chancroid	2	1	2
Typhoid fever	0	0	1
Salmonella	11	7	2
Undulant fever	0	0	0
Shigella	5	2	2
Amebic dysentery	0	1	5
Scarlet fever & strep. throat	362	445	169
Diphtheria	2	0	0
Whooping cough	4	1	6
Meningitis	4	1	5
Tularemia	0	0	1
Tetanus	3	0	1
Poliomyelitis	0	0	0
Encephalitis	0	0	0
Smallpox	0	0	0
Measles	0	0	120
Chickenpox	24	50	126
Mumps	5	35	89
Infectious hepatitis	32	35	35
Typhus fever	0	0	0
Malaria	2	1	0
Cancer	391	388	494
Pellagra	0	0	0
Rheumatic fever	9	16	20
Rheumatic heart	13	13	27
Influenza	649	42,335	198
Pneumonia	302	581	332
Rabies—Human cases	0	0	0
Pos. animal heads	3	5	0

As reported by physicians and including deaths not reported as cases.

*E. E.—The estimated expectancy represents the median incidence of the past nine years.

BUREAU OF VITAL STATISTICS
PROVISIONAL BIRTH AND DEATH STATISTICS AND COMPARATIVE DATA

Ralph W. Roberts, M. S., Director

NOVEMBER 1968

Live Births / Deaths / Causes of Death	Number Registered During November 1968			Rates* (Annual Basis)		
	Total	White	Non-White	1968	1967	1966
Live Births	5,103	3,390	1,713	17.3	17.7	18.3
Deaths	2,556	1,795	761	8.7	9.1	9.1
Fetal Deaths	104	56	48	20.0	20.4	19.8
Infant Deaths						
under one month	111	77	34	21.8	20.7	19.8
under one year	151	90	61	29.6	30.7	30.0
Maternal Deaths	3	1	2	5.8		3.7
Causes of Death						
Tuberculosis, 001-019	9	4	5	3.0	5.8	5.9
Syphilis, 020-029	3	1	2	1.0	1.4	2.1
Dysentery, 045-048	1		1	0.3		0.3
Diphtheria, 055					0.7	
Whooping cough, 056						
Meningococcal infections, 057					0.3	0.7
Poliomyelitis, 080, 081					0.3	
Measles, 085						
Malignant neoplasms, 140-205	380	287	93	128.6	128.4	127.5
Diabetes mellitus, 260	55	30	25	18.6	18.1	13.1
Pellagra, 281						
Vascular lesions of central nervous system, 330-334	306	194	112	103.6	125.7	128.9
Rheumatic fever, 400-402					1.0	0.3
Diseases of the heart, 410-443	897	684	213	303.6	304.3	308.2
Hypertension with heart disease, 440-443	100	46	54	33.8	38.9	36.3
Diseases of the arteries, 450-456	47	30	17	15.9	24.6	24.5
Influenza, 480-483	1	1		0.3	1.4	0.3
Pneumonia, all forms, 490-493	53	31	22	17.9	24.9	28.0
Bronchitis, 500-502	9	7	2	3.0	3.8	1.7
Appendicitis, 550-553	3	1	2	1.0	0.3	1.4
Intestinal obstruction and hernia, 560, 561, 570	10	8	2	3.4	3.1	3.8
Gastro-enteritis and colitis, under 2, 571.0, 764	5	2	3	1.7	1.0	2.1
Cirrhosis of liver, 581	21	14	7	7.1	5.5	5.2
Diseases of pregnancy and childbirth, 640-689	3	1	2	5.8		3.7
Congenital malformations, 750-759	21	16	5	4.1	6.0	5.5
Immaturity at birth, 774-776	33	22	11	6.5	6.0	5.8
Accidents, total, 800-962	224	170	54	75.8	70.7	63.9
Motor vehicle accidents, 810-835, 960	140	111	29	47.4	38.2	33.9
All other defined causes	337	228	109	114.1	122.9	126.4
Ill-defined and unknown causes, 780-793, 795	138	64	74	46.7	47.8	45.6

*Rates: Birth and death—per 1,000 population
Infant deaths—per 1,000 live births
Fetal deaths—per 1,000 deliveries
Maternal deaths—per 10,000 deliveries
Deaths from specified causes—per 100,000 population

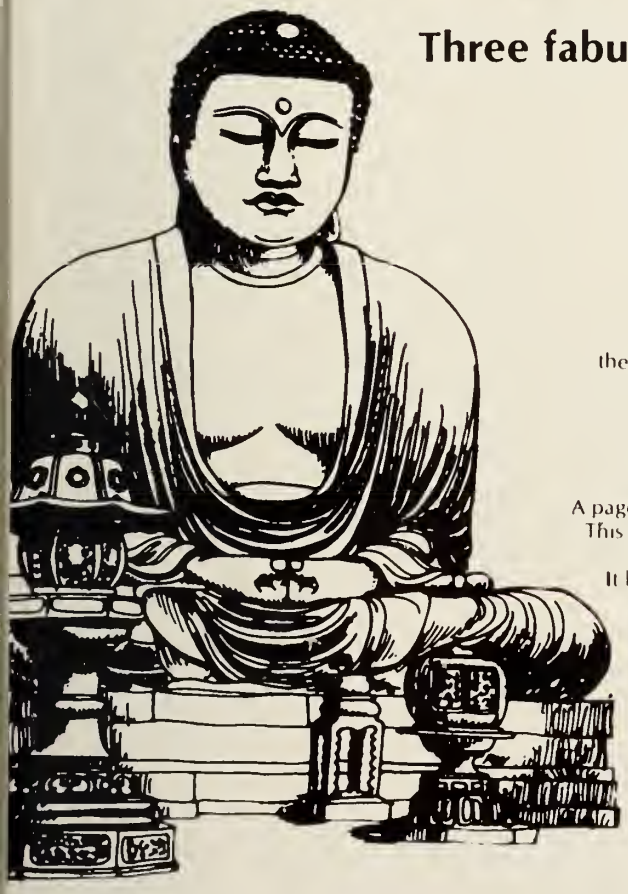
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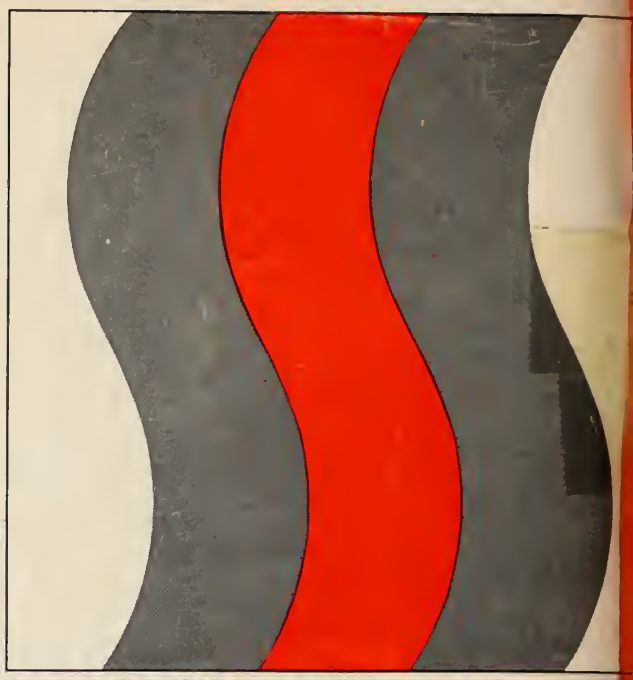
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Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.
Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

CONVENTION PROGRAM ISSUE

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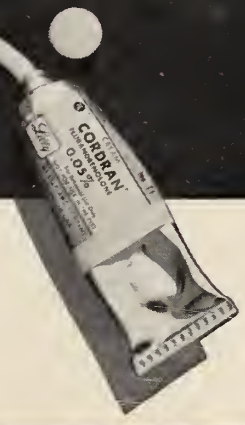
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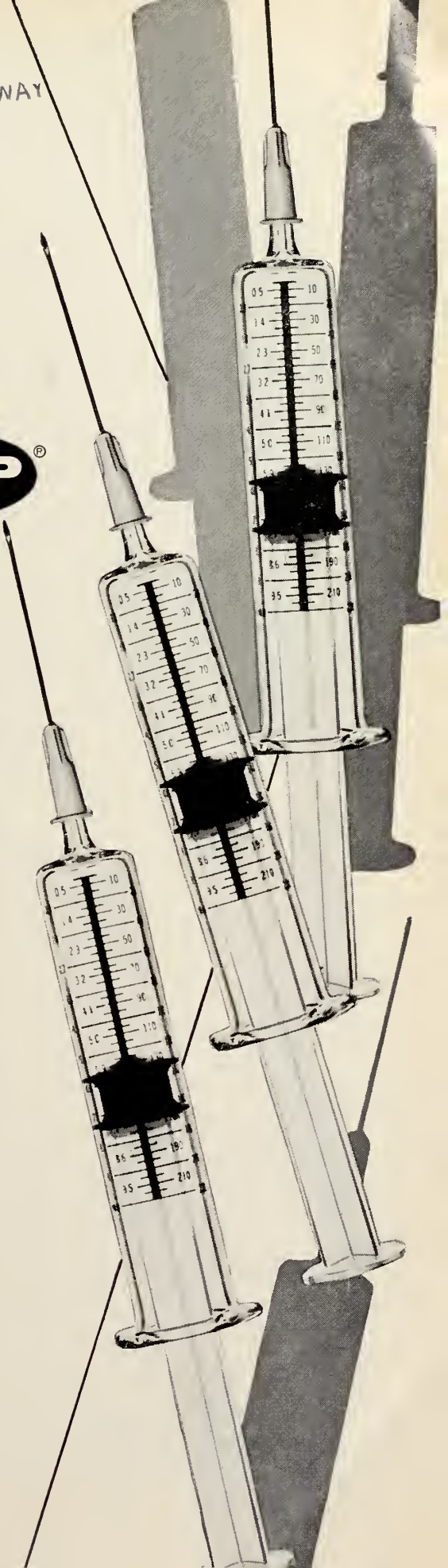
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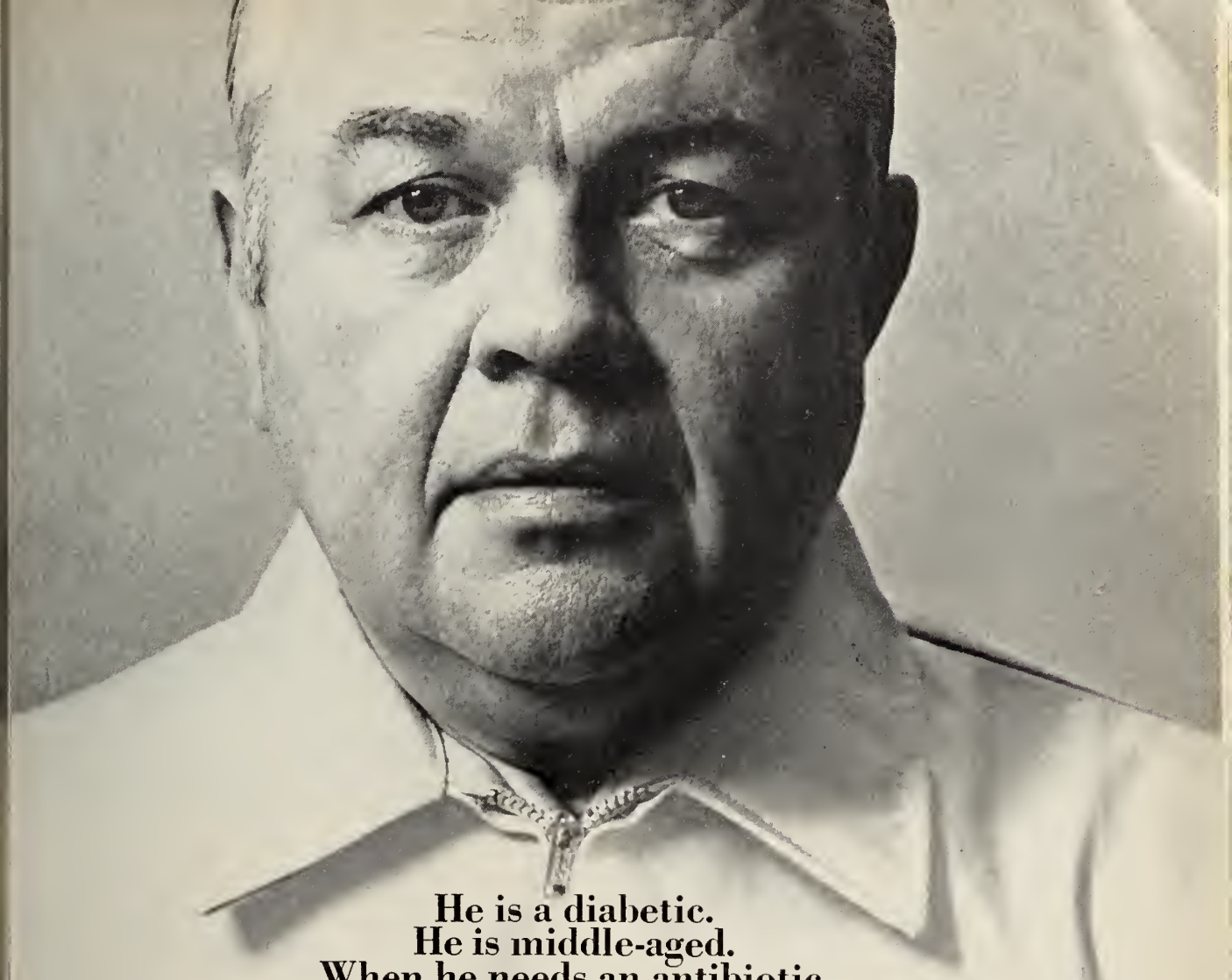
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traindication: History of hypersensitivity to demethylchlortetracye or nystatin.

rning: In renal impairment, usual doses may lead to excessive accumion and liver toxicity. Under such conditions, lower than usual doses indicated, and, if therapy is prolonged, serum level determinations be advisable. A photodynamic reaction to natural or artificial sunt has been observed. Small amounts of drug and short exposure may duce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoergic reactions have been reported. Patients should avoid direct posure to sunlight and discontinue drug at the first evidence of skin comfort. Necessary subsequent courses of treatment with tetracyes should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

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President's Page



E. L. McCafferty, Jr.

As my time of office as your president draws to a close it is with a great sense of appreciation that I look back over the past year on the honor that you have bestowed on me and the opportunities of knowing and working with the many fine people throughout the state. This opportunity renews one's confidence in that statement that "Physicians are the finest people of all the professional groups, and are unselfishly dedicated to the welfare of their patients." To all of you, I thank you for your interest and support during my term of office.

I also wish to express my appreciation to Dr. Kermit Pitt for his counsel throughout the year and congratulate you on having selected a fellow physician who, I believe, will serve you unselfishly and whose good judgment will be reflected in the policies and programs of your Association.

As I have done so many times before, I again express my appreciation to our dedicated central office staff for their fine efforts in our behalf.

The Board of Trustees will meet on Wednesday, April 23, 1969, at the Carriage Inn. At this time it is hoped that the representatives of the various county components of our State Association will meet with us and present their views regarding the various subjects that they are concerned with, and at the same time present plans and programs for consideration by the Board of Trustees.

Since Title XIX will most probably be implemented at the next regular session of the State Legislature, it will be well to review your thinking for the guidance of your officers prior to its final submission by the Health Department for implementation. This is a far-reaching program initially involving one hundred million dollars, and gradually expanding its services until 1975. This program in contradistinction of some more recent programs will sooner or later touch on the practice of each physician in this state, and should be thoroughly understood by all of our members prior to its implementation. Dr. Alphin, Director of this program, will be invited to attend this meeting in order to be available for any questions that may be of interest to you.

Other legislative programs which will also be presented include air pollution. The air pollution bill and its importance as a public health measure have been called to your attention on several occasions. Since this bill, along with water pollution, will be tremendous public health problems within the fore-

seeable future, it behooves all of us to be aware of this legislation intended to protect the public and to take realistic steps now before a pollution crisis arises such as has afflicted so many of our great cities in industrialized areas.

The question of liability insurance and some of the suggestions that have been made in the expectation of ultimately reducing our premiums and the number of malpractice claims will also be open for discussion as well as the statewide group policy with Blue Cross-Blue Shield coverage for physicians in the rural areas.

These are examples of the responsibility that you assume as a Delegate of your county society or as a Counsellor, and in my mind can only be discharged in advising your elected Association and Health Department officers as to the course that you wish them to pursue.

I hope that each of you will plan to attend this Annual Session in Huntsville, and we look forward to seeing you there.

E. L. McCafferty Jr.

AAPS House of Delegates Meets

The Association of American Physicians and Surgeons House of Delegates will hold a two-day meeting April 11 and 12 at the Continental Plaza Hotel, Chicago, with Dr. Edward P. Daly presiding at the opening session and later over a Finance for Special Activities committee. W. Cleon Skousen, author and faculty member, Brigham Young University, Utah, will be the banquet speaker Friday evening.

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AUXILIARY PLEDGE

"I pledge my loyalty and devotion to the Woman's Auxiliary to the American Medical Association. I will support its activities, protect its reputation and ever sustain its high ideals."

On January 28, I was privileged to visit the Walker County Auxiliary, in Jasper. The Medical Society and the Auxiliary had dinner together at the Peoples Hospital, then adjourned to their respective meetings. As I spoke to the members of this Auxiliary, I emphasized the use of the three keys: Enthusiasm, Good Programs and Worthy Projects. As I speak to the Auxiliaries, I remind the members of the purpose of our organization, and try to give helpful suggestions for programs and projects that will be practical for that particular Auxiliary. I am always happy when we have a discussion period following my message, and a question and answer period.

My final assignment in January was to preside at the Executive Board meeting in Bessemer on the 30th, at which time several items of business were discussed, as well as final plans for the State Convention and the National Convention, when the Medical Association and the Auxiliary of Alabama will honor Belle Chenault at a reception.

On February 4, I was the guest speaker at the Elmore-Tallapoosa Auxiliary meeting on Lake Martin, Alexander City. The Health Careers Congress, at the Jefferson Davis Hotel, Montgomery, February 6 and 7, was excellent, and the attendance was very gratifying. I was very much impressed with the speakers in the panel discussion, with whom the students had an opportunity to speak in small groups, discussing the health careers in which they are most interested. The results of this meeting will be far-reaching.

The Tuscaloosa-Hale Auxiliary meeting was held at Bryce Hospital Dining Room on February 20, a Luncheon meeting. The guest speaker was Reverend Benjamin Smith, who



Mrs. Robert K. Wilson, Sr.

was the speaker at the N. W. District meeting in Decatur. On this occasion, he spoke of his duties as Chaplain at the Medical Center. When he began his duties there four years ago, he was one of four holding like positions, and now there are 70. He is very enthusiastic about his work, and enjoys his contacts with the students and their wives, in the role of spiritual advisor and counselor. He was also the speaker at the Montgomery Auxiliary meeting the following day, in Montgomery, when he spoke on "How to be a Person, as well as a Doctor's Wife."

I received my copy of "The Direct Line" yesterday. This is a Newsletter for Auxiliary leaders, and one of the articles appealed to me very much. It stated that Success is a 7-letter word, spelled with 7 P's: planning, per-

sonality, personnel, programs, projects, perseverance and patience. Each one of these was ably discussed, in the light of Auxiliary work, and I was especially impressed with "Personality," which stated that like people, different Auxiliaries have different personalities, and that in planning, we should constantly be aware of the personality of our particular Auxiliary. I wanted to say "Amen" to everything in this article, and wondered who the author was. At the end of the article, I found that it was Belle Chenault.

As this is my last President's Page, I would like to take this opportunity to express my appreciation to all who have helped to make this one of the finest years of my life. It will always be a highlight to me, and I have many pleasant memories of this experience. I have enjoyed my association with the Board of Trustees, as I have attended their monthly meetings, and I have the greatest admiration for Dr. McCafferty, his ability, his friendliness, and his fine leadership.

Serving as President of the Auxiliary has given me a deeper insight into the role of the doctor's wife and I feel sure that I will be a more dedicated Auxiliary member. It has been a joy to visit the Auxiliaries throughout the state and to see the members in action, as they are serving in their communities, improving conditions for their fellow man, all the while assisting the Medical Association and bringing about a closer relationship between the physicians' families.

Louise M. Wilson

(Mrs. Robert K. Wilson, Sr.)
President, WAMASA



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An all new homelike psychiatric residence located on a lovely five-acre tract inside the city, providing a comprehensive range of services, including inpatient (28 beds), day care, and outpatient treatment. The therapeutic setting is an open community one with no provisions for locked wards. Each patient participates in an intensive treatment program consisting of individual pyschotherapy, group psychotherapy, topical small group discussions, occupational therapy and recreational therapy, and other group activities in the Center as well as in the community, depending on individual interests and needs. Drugs are used when appropriate.

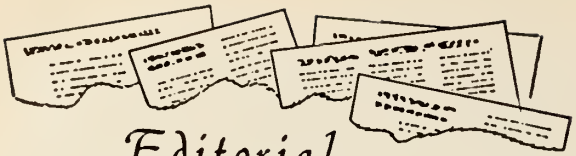
Any individual may be admitted who, in the opinion of the staff, might benefit from the services provided in this particular setting. This can best be determined by a preadmission consultation with the person and a responsible member of his family.

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Editorial COMMENT

Cigaret Ads On Television Are Encouraging Smoking

"Anybody with 'pot' in his name cannot be all bad," quipped the Rev. Dr. Coffin, of Yale University, who forced his way onto the Auburn campus and into the auditorium, waving a federal court order.

He was speaking, according to one witness, of Auburn's president, President Philpott, who had done his best to keep Coffin from advertising his peculiar brand of Americanism through the facilities of an Alabama university.

His appearance was in as bad taste as would be a cigaret advertisement in a medical magazine.

The power of advertising is well recognized. Whether oral or written, it has been developed scientifically to such a high degree of persuasiveness that limitations are being wrapped around it.

For instance, in a beer ad on TV, you'll never see one raise a frosted glass or mug to his lips and drink! There's a law against it.

Seeing an actor on the movie screen draw a puff of cigaret smoke deep into his lungs can seem so enjoyable that heavy smokers in the audience feel an overpowering urge to go to the outer lobby and light up. A comfortable pipe or a personable cigar can do the same thing.

The Journal of the Medical Association of the State of Alabama accepts no liquor and no tobacco advertising. It could not in good conscience do so, any more than it would accept advertising glorifying the delights of an opium dream.

To that extent, we must be our brother's keeper.

The evidence is indisputable that at least 75 per cent of lung cancer is traced directly to the door of cigaret smoking. The manufacturers have been forced to put a warning note on the outside of each pack of cigarets, just as the skull-and-crossbones labels a bottle of poison.

And finally the FCC is demanding that cigaret advertising be banned from the television screen.

Those who oppose this restriction are in the position of the teacher who challenged Ann Landers the other day.

A disturbed young girl, who admittedly would not be ready for marriage for several years, was being urged by her boy friend to study together a book on marital sex. She appealed to the popular columnist for advice, and Ann used no gloves to pad her stern reply.

This answer drew a letter of protest from a teacher that she was "opposing sex education." In the name of "academic freedom," this teacher was arguing for this kind of mutual study, ignoring Ann's declaration that, like an aphrodisiac movie, it would lead directly to the back seat of a car parked in a lonely lane.

It will be interesting to see how much longer persuasive cigaret advertising will be permitted a place on the television screen.

(Continued on Page 885)



vacation in a vial: the spasm reactors in your practice deserve

"the Donnatal® Effect"

	each tablet, capsule or 5 cc. of elixir (23% alcohol)	each Donnatal No. 2	each Extentab®
ıyoscyamine sulfate	0.1037 mg.	0.1037 mg.	0.3111 mg.
ıtropine sulfate	0.0194 mg.	0.0194 mg.	0.0582 mg.
ıyoscine hydrobromide	0.0065 mg.	0.0065 mg.	0.0195 mg.
)henobarbital	(¼ gr.) 16.2 mg.	(½ gr.) 32.4 mg.	(¾ gr.) 48.6 mg.
(Warning: may be habit forming)			

Brief Summary. Blurring of vision, dry mouth, difficult urination, and flushing or dryness of the skin may occur on higher dosage levels, rarely on usual dosage. Administer with caution to patients with incipient glaucoma or urinary bladder neck obstruction. Contraindicated in acute glaucoma, advanced renal or hepatic disease or a hypersensitivity to any of the ingredients.

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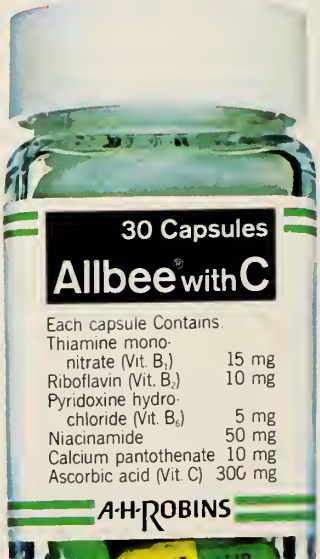
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Two ways to provide your patients with a month's therapeutic supply of Vitamin C:



290 tangerines or 30 Allbee® with C.

Your patient would have to peel and eat 290 tangerines a month, almost 10 every day, to get as much Vitamin C as is contained in just one bottle of 30 Allbee with C capsules (taken one capsule daily). In addition, each capsule provides full therapeutic amounts of the B-complex vitamins. For example, as much niacin as 2 pounds of sirloin steak. This handy bottle of 30 Allbee with C capsules gives your patient a month's supply at a very reasonable cost. Also the economy size of 100. Available at pharmacies on your prescription or recommendation.



A.H. Robins Company, Richmond, Va. 23220

Annual AMA Convention Offers Variety Of Valuable Attractions

There'll be more time than usual this year between the annual meeting of the Medical Association of the State of Alabama (April 24-26) and the annual convention of the American Medical Association (July 13-17), the one in Huntsville, Ala., the other in New York City.

So, the largest of the many meetings sponsored annually by the AMA is still far enough away for Alabama doctors to include it in their advance planning.

This meeting covers so much of professional interest, and attracts so many physicians, members of allied health professions, industrial exhibitors, and guests, that only a relatively few cities have ample facilities to accommodate it. Coming as it does in the midst of summer, it might be pointed out that not only is New York more widely air conditioned than any other Northern city, but its weather can be pleasant in July, supplemented by cool ocean breezes.

For the many physicians who take their families to the AMA Annual Convention, the New York City area obviously offers many and varied attractions.

There is no question about the benefits for the physician. Among other things, there is opportunity to ask questions, discuss techniques and developments with experts, and enter into dialogue which no other means of medical communication allows so extensively and instantaneously.

Four general scientific meetings are offered, as well as 23 section programs (with the Section on Special Topics offering six sessions), breakfast roundtables and fireside conferences.

Additional postgraduate education is available through the exhibits, medical motion pictures and scientific television presentations.

Juries Generally Are Punishing Themselves In Malpractice Verdicts

Malpractice suits against physicians and surgeons may originally have been designed —like libel laws for newspapers and like alimony payments for divorcees—to protect the victims.

Today, even more than the libel laws, they have become a kind of punishment for the unwary, a means of stifling resourcefulness . . . and for some unscrupulous lawyers and ex-patients, a way to get something for nothing; like the speed traps that once enriched the coffers of small towns.

In the years between World Wars I and II, it became common practice for petit juries to award heavy damages against railroads, street car and power companies, and automobile drivers, solely because "they are insured," and without regard to the merit of individual cases. None seemed to realize that every responsible American was helping foot the bill for these petty larcenies, through increased insurance rates.

Unlike "big government," we individual Americans have to balance our budgets. When a cost goes up for us, we pass along as much of it as possible to others.

So the American public must come to realize that it generally and ultimately will be paying the cost of damages awarded and the risk involved in insurance policies cancelled by the jury verdicts in malpractice suits.

And the American physician must be increasingly alert to the "speed traps" that could lead to malpractice litigation.

To Kill Time—And Opportunity! —Try 'Passive Entertainment'

"Passive entertainment" (the movies and TV) received a rap on the knuckles in a recent article in a popular magazine distributed free by a grocery chain in Alabama. The article was on the encouragement of creativity in little people and observed that:

"Children who are forced to rely on their own ingenuity must use their creative capacity, and through exercising it, will stimulate further growth."

The hobby of killing time, it occurs to us, should be reserved for those oldsters intent on sleeping the rest of their lives away, whether before a television screen, in the comfortable dark of a movie theater, or in an easy chair at home, a newspaper on the floor or a book in the lap.

There is where passive entertainment becomes a soporific.

Without benefit of such present-day diversions, the child Albert Einstein convinced his teachers that he was "retarded." In a report to his father, his tutors tagged him "mentally slow, unsociable, and forever adrift in his foolish dreams."

Had he replaced those dreams with the grotesqueries of juvenile screen shows or with the premature stimulus of sex displays for "adult" audiences, there might be today no law of relativity, no nuclear power.

Passive entertainment is no exclusive of youth. If it is an index of immaturity, then it goes only to prove that some of us never grow up. In fact, a lot of us indulge in it most of the time, and all of us some of the time.

It is a way of relieving the tensions of the day. But, like a shot in the arm, it can be overdone—and frequently is.

Incoming ACS Director

C. Rollins Hanlon, M. D., professor of surgery and chairman of the department of Surgery, St. Louis University School of Medicine, St. Louis, will become director of the American College of Surgeons next Oct. 10, at the close of the College's 1969 Clinical Congress in San Francisco.



Dr. Hanlon

He succeeds Dr. John Paul North, who had informed the Board of Regents two years ago that he intended to retire in 1969.

Dr. Hanlon is a native of Baltimore. His medical education at Johns Hopkins was interrupted by wartime service in the Navy. Now a member of the College's Cardiovascular Committee, elected its chairman two years ago, he also heads a committee of the Board of Regents charged with the establishment at College headquarters of an international registry of human transplantation cases.

Dr. Hanlon will be the fifth director of the American College of Surgeons, which now numbers more than 30,000 Fellows in the United States, Canada, and some 90 foreign countries.

NURSE'S RATE SCHEDULES SET

Minimum employment standards for private duty nurses, approved by the Alabama State Nurses' Association and effective now, set a daily rate for a consecutive eight-hour schedule or fraction of it, $28. An hourly rate schedule may be set up where the total time is limited, with $9 for the first hour, and $4 for each hour or fraction of an hour beyond that, not to exceed four hours.

Time in excess of eight consecutive hours is paid at the rate of time and a half.


Blue Shield's new URC program is designed to minimize your collection problems through payments based on physicians' usual, reasonable and customary fees.
BLUE CROSS-BLUE SHIELD OF ALABAMA ®

Alabama MD's And Their Role In Adoptions

Reginald T. Hamner, LL. B.

The Alabama laws governing adoption of minor children are such that the process is usually a lengthy one. Child placing agencies and the courts both tend to move slowly and cautiously. Couples, therefore, in their haste to secure a child, and possibly also to avoid contacting an authorized agency, may turn to an intermediary for assistance.

This intermediary, or third party, frequently is their physician. Since a physician is likely to be the first person an expectant mother turns to for advice upon learning she is pregnant, a couple may reason that their physician will know of an adoptable child for them. Whether it is the expectant mother or the would-be adopting parents who come to him, the physician should be most cautious in giving his advice.

The role of the physician in the adoption process is an important one and a proper one—but it is not that of finding a home for a baby or an infant for a childless couple. The physician's responsibility is evaluation of the physical and mental conditions of the principles in an adoption situation—whether it be that of the infant, of the natural parents or that of the prospective parents or even of all three.

Title 27, Section 7 of the *Code of Alabama*, 1940 (Recomp. 1958) states:

> "It shall be unlawful for *any person* or persons, organizations, hospitals, or associations which have not been licensed by the state department of public welfare to advertise that they will adopt children, or place them in foster homes, or hold out inducements to parents to part with their offspring, or *in any manner knowingly become a party to separation of a child from its parents,* or guardian except through commitment of a juvenile court or other court of like jurisdiction. (Emphasis added.)"

The statute provides further that a mother may place her child and consent to its adoption. Such an independent placement, however, becomes a violation of law when an unauthorized person finds the child for the parent or seeks a child for prospective parents who wish to adopt one. However, the adoption of a minor child can take place only with the consent of the parents, the consent of the legal guardian when parents have lost custody, by judicial process or, in cases of illegitimacy the consent of the mother alone unless there has been a proceeding in which the paternity of the child has been established.

While the term "independent placement" has been ascribed in general to the situations in which the parent places an unwanted child with persons desiring to adopt a child, such a placement is an illegal one only when a third party is involved. An "independent placement" does not necessarily come to the attention of the State Department of Pensions and Security until such time as the petition for adoption is filed. With the filing of the petition in the probate court, the court is then required to notify the State agency.

What, then, *is* the proper responsibility of the physician when he is asked for adoption advice beyond his duty in the area of medical evaluations of the parties concerned. The physician should refer to the State Department of Pensions and Security or their county department of pensions and security those persons wishing to give up a child and those wishing to adopt a child. The Alabama leg-

islature vested in this State agency the authority to place unrelated children for adoption or license other agencies to do so. At present the Department of Pensions and Security has licensed several agencies to place children for adoption. Persons desiring adoption service or advice may contact one of these approved agencies, the State Department of Pensions and Security or their county department. These approved agencies are: The Bureau of Catholic Charities in Montgomery, Mobile, Birmingham and Huntsville, The Child and Family Service in Mobile, The Children's Aid Society of Jefferson County in Birmingham and The Methodist Children's Home in Selma.

Statistics show that more petitions for adoptions are filed in the probate courts each year than there are children placed for adoption by approved agencies. Many of these children are adopted by relatives—i.e. stepparents, grandparents, uncles, aunts, etc. Nevertheless, the figures indicate that "independent placements" are taking place within Alabama. There is no precise data of whether or not such placements are the result of activity by a third party or represent a direct placement by the mother.

Persons who obtain children and the necessary written consent from the parents must still petition the probate courts to legalize the adoption of such children. When the probate court notifies the State Department of Pensions and Security that the adoption petition has been filed, this Department or its designated agent will then conduct an investigation of the facts surrounding the adoption and make a recommendation to the court. A written report is filed by the Department with the probate court and should the Department recommend that the proposed adoption be disapproved, a motion may be made asking the court to dismiss the adoption petition. Such action does not mean that the probate court cannot or will not grant the prospective adoptive parents' petition. Even in instances where an original placement may have been illegal, the probate court may legally grant the petition for adoption.

The primary objection raised by those who wish to adopt children and turn to intermediaries is the long waiting period required in the present process. The agency requires time to complete the investigation of the home, and additional time before and after placement of the child. It is this same time element in the whole adoption process, though often lengthy, which is designed to help both the child and the adoptive parents.

Upon the filing of an application with an approved placement agency, a full study is made considering the suitability of the prospective adoptive parents, the background of the child, and their mutual compatibility. The agency placement will not be made until the child is legally available for adoption, by first having had the rights of the natural parents terminated by a court proceeding. This eliminates any future contact by either of the natural parents, and, at the same time, greatly diminishes the likelihood that either of the natural parents will later seek to regain custody of the child.

Any person who becomes involved in the role of an adoption intermediary is guilty of a misdemeanor. The penalty for violation of the adoption statute is a fine of not more than $100 or imprisonment for not more than three months in the county jail. Both penalties may be imposed since the degree of punishment is discretionary with the trial court.

In addition to the legal consequences for violation of the law, the person who brings about an adoption placement subjects both the child and the adoptive parents to the possibility that the petition for adoption will not be granted or what is equally or more critical, that at some future date a tragic custody fight will result. There can be an ever present fear of losing the child.

The Medical Association of the State of Alabama recognized that the prohibition against "independent placement" by a third party could affect and involve its members by virtue of their profession. In 1955, a resolution was passed by this Association which acknowledged the physician's strategic posi-

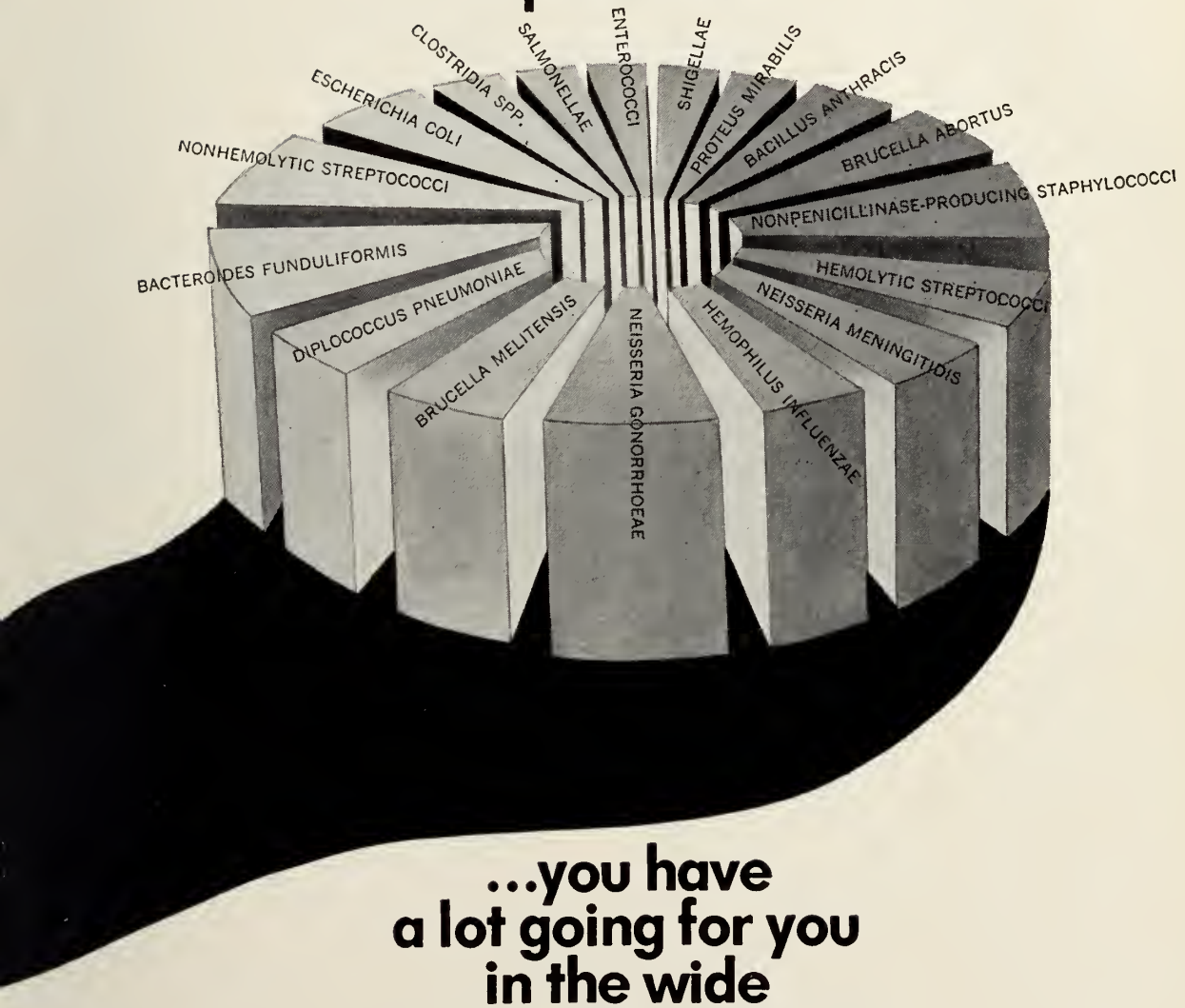
tion but encouraged that the placement of children for adoption be left to those social workers who are trained in this sensitive area. The resolution further called upon county societies to scrutinize their memberships to assure that their members were not involved in the "independent placement" of children.

Though the adoption procedure in Alabama may appear to be slow and may sometimes seem to impede placement of a particular child with a particular couple, these procedures were developed in the best interests of all concerned. They allow for social service to the mother before she releases her child, for social service to the adopting parents and provides other safeguards that result in the nearest possible substitute for an own home for each child who is adopted. The unhappy circumstances of unauthorized placements demonstrate the dangers therein. An illustration of this is a case which finally reached the Alabama Supreme Court and resulted in the return of a four year old child to his natural mother who had been coerced by a third party into giving him up at birth.

The process of adoption creates lifetime relationships that substitute for the natural ties of parent and child. The far-reaching consequences of adoption, therefore, make it essential for the law to surround the parties involved with every safeguard. The parental consent is the most important aspect of the procedure at the outset, and it should never be obtained through coercion or irregular means. An unauthorized placement does the child and the adopting parents a great disservice and offsets the protection inherent in the statutory process.



With the broad Polycillin (ampicillin trihydrate) spectrum...



...you have a lot going for you in the wide range of bacterial infections.

PRESCRIBING INFORMATION. For complete information consult Official Package Circular. **Indications:** Infections due to susceptible strains of Gram-negative bacteria (including Shigellae, *S. typhosa* and other Salmonellae, *E. coli*, *H. influenzae*, *P. mirabilis*, *N. gonorrhoeae* and *N. meningitidis*) and Gram-positive bacteria (including streptococci, pneumococci and nonpenicillinase-producing staphylococci). **Contraindications:** A history of allergic reactions to penicillins or cephalosporins and infections due to penicillinase-producing organisms. **Precautions.** Typical penicillin-allergic reactions may occur, especially in hypersensitive patients. Mycotic or bacterial superinfections may occur. Experience in newborn and premature infants is limited and caution should be used in treatment, with frequent organ function evaluations. Safety for use in pregnancy is not established. In gonorrheal therapy, serologic tests for syphilis should be performed initially and monthly for 4 months. Assess renal, hepatic and hematopoietic function intermittently during long-term therapy. **Adverse Reactions:** Skin rash, pruritus, urticaria, nausea, vomiting, diarrhea and anaphylactic reactions. Mild transient elevations of SGOT or SGPT have been noted. Black tongue has been noted in some patients receiving the Chewable Tablets. **Usual Dosage:** Adults—250 or 500 mg. q. 6 h. (according to infection site and offending organisms). Children—50-100 mg./Kg./day in 3 to 4 divided doses (depending on infection site and offending organisms). Bacterial meningitis—150-200 mg./Kg./day in 6 to 8 divided doses. Children weighing more than 20 Kg. should be given an adult dose when prescribing orally. In parenteral administration, children weighing more than 40 Kg. should be given an adult dose. Beta-hemolytic streptococcal infections should be treated for at least 10 days. **Supplied:** Capsules—250 mg. in bottles of 24 and 100. 500 mg. in bottles of 16 and 100. For Oral Suspension—125 mg./5 ml. in 60, 80 and 150 ml. bottles. 250 mg./5 ml. in 80 and 150 ml. bottles. Chewable Tablets—125 mg. in bottles of 40. Injectable—for I.M./I.V. use—vials of 125 mg., 250 mg., 500 mg., and 1 Gm. Pediatric Drops—100 mg./ml. in 20 ml. bottles.

11-1/2/69 **A.H.F.S. Category 8:12.16**

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The Outlook for the Paper Industry

W. L. Whiting, III

Paper stocks have not been market favorites for some time. After World War II, paper companies registered good earnings gains, and their shares were excellent market performers—especially in the 1953-56 period when they were regarded as growth stocks. After the peak year of 1956, earnings fluctuated with the economy for a decade before reaching a new peak in 1966, only to fall again in 1967 and then to recover slightly in 1968. Stock prices also made little, if any, progress—most paper issues traded in narrow ranges during the 12 years from 1956 to 1968.

Mr. Whiting is account executive for Merrill Lynch, Pierce, Fenner and Smith, Inc., in Mobile, Alabama.

It is our opinion that a bullish attitude toward paper stocks is justified by what appears to be the beginning of a period in which earnings and stock prices could advance significantly. We estimate that during the next three years earnings for most paper companies could increase some 50 per cent, and that a possible rise in price-earnings ratios could well lead to a doubling of current share prices. The favorable outlook for the paper industry on a cyclical basis may be generally recognized, but we believe it is more significant that the longer-term prospects have improved. A number of developments lead us to believe that earnings in the paper industry during the next ten years will far exceed the relatively dismal record of the last 12 years. If that fundamental change in operating results occurs, we expect it to be accompanied by improved price action for paper stocks, which could become one of the leaders in the over-all market.

Among the favorable conditions that we foresee in the operating environment are the following:

Additions to capacity will be more moderate during the next few years than they have been in the recent past. The latest annual survey of capacity by the American Paper Institute shows that during the three years 1969-71, the industry plans to add 3.9 million tons of paper and paperboard capacity and 2.5 million tons of wood-pulp capacity. During the previous three years (1966-68) the industry added 8.5 million tons of paper and paperboard capacity and 5.6 million tons of wood-pulp capacity. If demand for the industry's products expands at the rate of the past during the next three years, new capacity should be quickly assimilated, and both

(Continued on Page 898)

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"Where the Action Is!"

this ulcer did not heal...until its surface was cleared of dead tissue and debris



FIRST APPLICATION
ELASE Ointment is applied to a deep ulceration of a finger.

EIGHTEEN DAYS LATER
Healing has progressed rapidly without interruption or interference from any accumulated purulence or necrotic tissue. Greatly reduced size of lesion and minimal scar tissue indicate quality and vigor of healing which is almost complete.



to aid in debridement
to facilitate healing
in chronic cutaneous ulcers...

Elase® Ointment

(fibrinolysin and desoxyribonuclease, combined, [bovine] ointment)

PARKE-DAVIS

By helping to remove dead tissue and debris from the ulcer's surface, ELASE Ointment creates a better environment for the elimination of infection, for healthy granulation...*for healing*. Its lytic enzymes effectively break down DNA in dead leukocytes and other debris...the fibrin in blood clots, serum, and purulent exudates...and the denatured proteins in necrotic tissue. Protein elements of *living* tissue are relatively unaffected. ELASE Ointment is indicated in stasis ulcers and in other infected or inflamed ulcers caused by circulatory disturbances. In cases requiring skin grafting, it is used preoperatively for debridement. For ambulatory patients debridement with ELASE Ointment is a convenient therapy and a regimen likely to be followed. *Precautions:* Observe usual precautions against allergic reactions, particularly in persons with a history of sensitivity to materials of bovine origin or to mercury compounds. *Adverse Reactions:* Side effects attributable to the enzymes have not been a problem at the dose and for the indications recommended. *Discussion:* Successful use of enzymatic debridement depends on several factors: (1) dense, dry eschar, if present, should be removed surgically before enzymatic debridement is attempted; (2) the enzyme must be in constant contact with the substrate; (3) accumulated necrotic debris must be periodically removed; (4) the enzyme must be replenished at least once daily; and (5) secondary closure or skin grafting must be employed as soon as possible after optimal debridement has been attained. It is further essential that wound-dressing techniques be performed carefully under aseptic conditions and that appropriate systemically acting antibiotics be administered concomitantly if, in the opinion of the physician, they are indicated. *Available:* ELASE Ointment is supplied in 30-Gm. tubes containing 30 units (Loomis) of fibrinolysin and 20,000 units of desoxyribonuclease with 0.12 mg. thimerosal (mercury derivative); and in 10-Gm. tubes containing 10 units of fibrinolysin and 6,666 units of desoxyribonuclease with 0.04 mg. thimerosal. ELASE Ointment has a special base of liquid petrolatum and polyethylene; contains sodium chloride and sucrose used during manufacture; is stable at room temperature through the expiration date stated on the package.

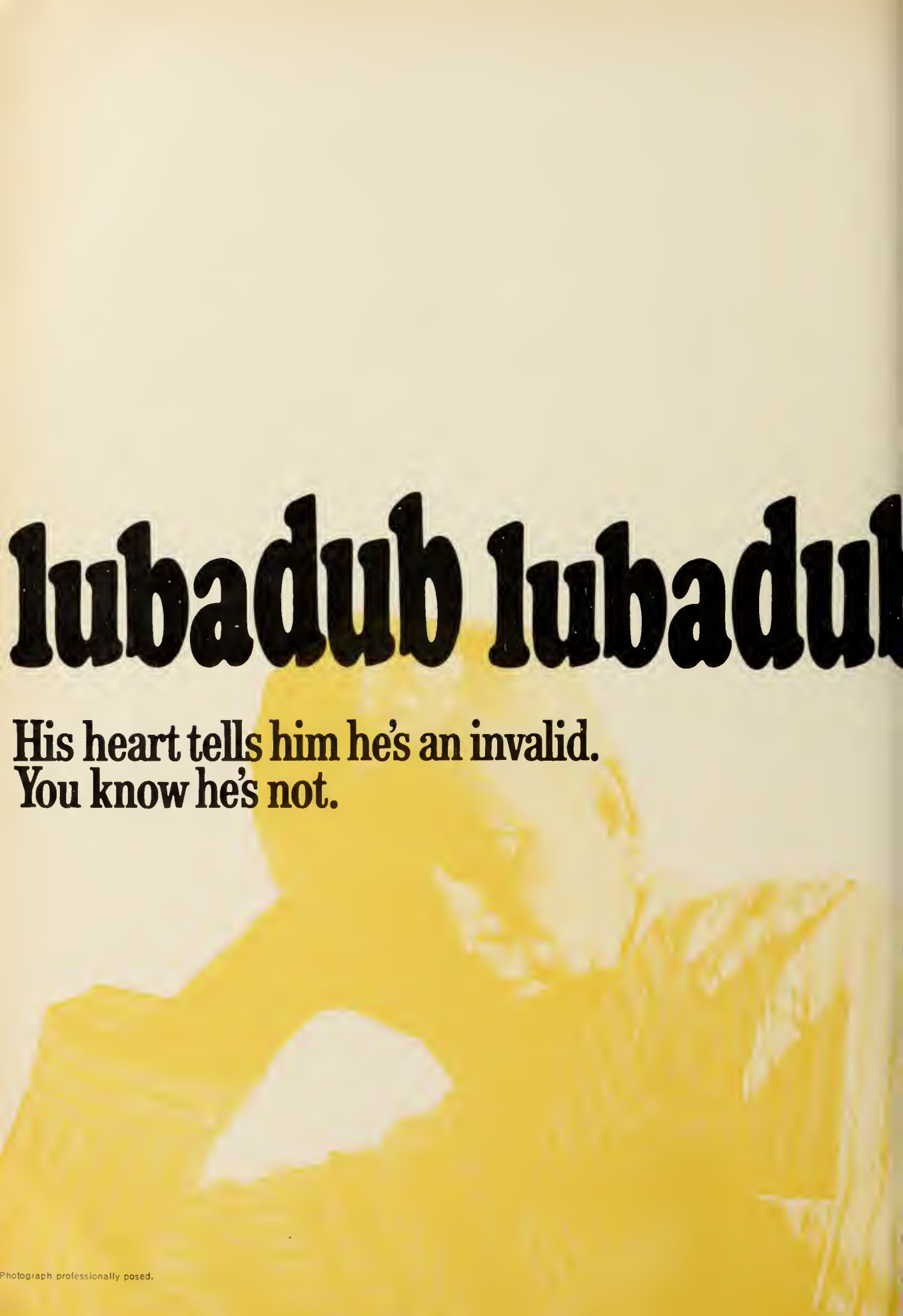
Parke, Davis & Company, Detroit, Michigan 48232

PARKE-DAVIS

48158

lubadub lubadub

His heart tells him he's an invalid.
You know he's not.



Photograph professionally posed.

Contraindications: History of sensitivity to meprobamate.

Important Precautions: Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use has been reported to result in dependence or habituation in susceptible persons, as alcoholics, ex-addicts, and other severe psychoneurotics. After prolonged excessive dosage, reduce dosage gradually to avoid possibly severe withdrawal reactions. Abrupt discontinuance of excessive doses has sometimes resulted in epileptiform seizures.

Warn patients of possible reduced alcohol tolerance, with resultant slowing of reaction time and impairment of judgment and coordination.

Reduce dose if drowsiness, ataxia or visual disturbance occurs; if persistent, patients should not operate vehicles or dangerous machinery.

Side Effects include drowsiness, usually transient; if persistent and associated with ataxia, usually responds to dose reduction; occasionally concomitant CNS stimulants (amphetamine, mephentermine sulfate) are desirable. Allergic or idiosyncratic reactions are rare, but such reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Previous history of allergy may or may not be related to incidence of reactions. Mild reactions are characterized by itchy urticarial or erythematous maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically as with epinephrine, antihistamine and possibly hydrocortisone. Aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia have occurred rarely, almost always in presence of known toxic agents. A few cases of leukopenia usually transient, have been reported on continuous administration.

Meprobamate may sometimes precipitate grand mal attacks in patients susceptible to both grand and petit mal. Extremely large doses can produce rhythmic fast activity in the cortical pattern. Impairment of accommodation and visual acuity has been reported rarely. After excessive dosage for weeks or months, withdraw gradually (1 or 2 weeks) to avoid recurrence of pretreatment symptoms (insomnia, severe anxiety, anorexia). Abrupt discontinuance of excessive doses has sometimes resulted in vomiting, ataxia, tremors, muscle twitching and epileptiform seizures. Prescribe very cautiously and in small amounts for patients with suicidal tendencies. Suicidal attempts have resulted in coma, shock, vasomotor and respiratory collapse and anuria. Excessive doses have resulted in prompt sleep; reduction of blood pressure, pulse and respiratory rates to basal levels; and occasionally hyperventilation. Treat with immediate gastric lavage and appropriate symptomatic therapy. (CNS stimulants and pressor amines as indicated.) Doses above 2400 mg./day are not recommended.

Composition: Tablets, 200 mg. and 400 mg. meprobamate. Coated Tablets, WYSEALS® EQUANIL (meprobamate) 400 mg. (All tablets also available in REDIPAK® [strip pack], Wyeth.) Continuous-Release Capsules, EQUANIL L-A (meprobamate) 400 mg.

Wyeth Laboratories Philadelphia, Pa.

Equanil®
(meprobamate) Wyeth®

ubadubdub lubadu

nxiety is expected in the cardiovascular patient.
little may even be desirable.

ut when anxiety is exaggerated . . . when it
terferes with sleep . . . when it aggravates
rdiovascular symptoms, your help may
e needed.

aturally, you'll want to reassure the patient.

nd perhaps prescribe Equanil (meprobamate)
adjunctive therapy. It helps relieve anxiety
d tension specifically, yet gently.

most 15 years' use has shown that Equanil
usually well tolerated as well as effective.
de effects are generally limited to transient
owsiness; serious, therapy-interrupting
de effects are rare.


P
M
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A little sunshine for summer cold and allergy sufferers.

vahistine LP can brighten things in urry for your summer cold and rgy patients.
ese continuous-release, deconges- t tablets contain a vasoconstrictor- ihistamine formulation that goes to rk promptly and usually provides ective relief even in those cases nasal congestion caused by repeated rgic episodes.
d, convenient twice-a-day dosage with Novahistine LP lets most patients enjoy relief all day and all night.
Use with caution in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

PITMAN-MOORE Division of
The Dow Chemical Company,
Indianapolis, Indiana.

DOW

Novahistine®
LP decongestant

(Each tablet contains 25 mg. of phenylephrine hydrochloride and 4 mg. of chlorpheniramine maleate.)

(Continued from Page 892)

operating rates and product prices should improve.

The availability and cost of timberland will be important determinants of the extent of industry expansion in the future. The large-scale construction of all kinds of forest-products facilities—pulp, paper, lumber and plywood—during the last 10-to-15 years has reduced the amount of available timberland and increased the costs of raw materials: and those conditions should have a moderating influence on long-term expansion in the paper industry.

New entrants into the paper industry should be less of a problem in the future. That prospect is another reason for believing that capacity additions will be less disruptive. Beginning in the 1950's, many lumber companies with large holdings of timberland constructed paper mills and converting plants in order to utilize their raw-materials bases more fully. In the future, however, the capacity plans of prospective entrants will be guided by the same considerations that govern expansion programs of existing paper companies—marketing ability and profit potential, we hope, will be foremost considerations.

Ownership of timberland by paper companies lends investment appeal to the group because investors tend to regard those natural resources as hedges against inflation and, of more importance, because the industry has begun aggressive exploration of alternate opportunities to realize profits on land holdings. A number of paper companies have initiated commercial, residential, or vacation-home-land development operations.

My current favorites within the paper group are St. Regis (39) and Westvaco (30). St. Regis earned $2.50 per share in 1968, our estimate for 1969 is for earnings to approach $2.75-$3.00. Westvaco reported earnings of $1.99 a share last year and earnings per share for 1969 should be around $2.20.

Milpath®

'MILPATH'-400: tridihexethyl chloride 25 mg. + meprobamate 400 mg.
'MILPATH'-200: tridihexethyl chloride 25 mg. + meprobamate 200 mg.

Usual Adult Dosage: 1 *'Milpath'-400* tablet, 3 times a day at mealtimes and 2 at bedtime. For greater anticholinergic effect, 2 *'Milpath'-200* tablets, 3 times a day at mealtimes and 2 at bedtime. Doses of meprobamate above 2400 mg. daily not recommended.
Contraindications: *Tridihexethyl chloride:* Urinary bladder-neck obstructions, e.g., prostatic obstruction due to hypertrophy; pyloric obstructions because of reduced motility and tonus; organic cardiospasm (megaesophagus); glaucoma; possibly in stenosing gastric or duodenal ulcers with significant gastric retention. *Meprobamate:* Previous allergic or idiosyncratic reactions to meprobamate.
Precautions: *Tridihexethyl chloride:* Use cautiously in elderly males (possible prostatic hypertrophy). *Meprobamate:* Carefully supervise dose and amounts prescribed. Consider possible dependence or habituation (reported occasionally after excessive use), particularly in severe psychoneurotics, alcoholics, ex-addicts. Withdraw gradually (1 or 2 weeks) after excessive dosage for weeks or months to avoid recurrence of preexisting symptoms (e.g., anxiety, anorexia, insomnia) or withdrawal reactions (e.g., vomiting, ataxia, tremors, muscle twitching; rarely, epileptiform seizures, more likely in those with CNS damage or latent convulsive disorders). If drowsiness or visual disturbance occurs, reduce dose and advise against activity requiring alertness (driving, machinery operation). Effects of excess alcohol may be increased. Grand mal seizures possible in persons with both petit and grand mal. Prescribe cautiously in small amounts to patients with suicidal tendencies. Prescribe with caution to patients with known sensitivity to compounds of similar chemical structure, e.g., carisoprodol.
Side Effects: The following side effects of components may occur with 'Milpath'. *Tridihexethyl chloride:* Severe effects rare on recommended dosage. Anticholinergic effects: dry mouth (fairly frequent at oral doses of 100 mg.), constipation or "bloated" feeling. Possible: tachycardia, dilation of pupils, increased ocular tension, weakness, nausea, vomiting, headache, drowsiness, urinary hesitancy or retention, dizziness. *Meprobamate:* Drowsiness, sometimes with ataxia, usually controlled by decreasing dosage, occasionally with aid of central stimulants (e.g., amphetamine). Rarely, allergic or idiosyncratic reactions (usually after 1-4 doses); in mild form: itchy, urticarial or erythematous maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever, transient leukopenia, and 1 fatal bullous dermatitis (after meprobamate and prednisolone) reported. More severe, very rare hypersensitivity: fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal), anuria, anaphylaxis, stomatitis and proctitis. Treat symptomatically (e.g., epinephrine, antihistamines, possibly hydrocortisone); stop and do not restart the drug. Isolated agranulocytosis, thrombocytopenic purpura, 1 fatal aplastic anemia reported, but only in presence of known toxic drugs; porphyric symptoms reported but relationship not established. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation reported by 1 observer. Fixed drug eruption with meprobamate and cross reaction to carisoprodol reported. Suicidal attempts may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse, and death. Excessive dosage has led rapidly to sleep, then reduction of vital signs to basal levels. Empty stomach, and if respiration becomes very shallow and slow, cautiously give CNS stimulants (e.g., caffeine, pentylenetetrazol, amphetamine); also pressor amines if indicated.
Before prescribing, consult package circular.

WALLACE PHARMACEUTICALS/Cranbury, N.J.



To calm the patient and curb his pain

helps relieve cramping G.I. pain by reducing spasm and excess secretion / helps allay the anxiety-tension that precipitates, aggravates, or results from G.I. distress

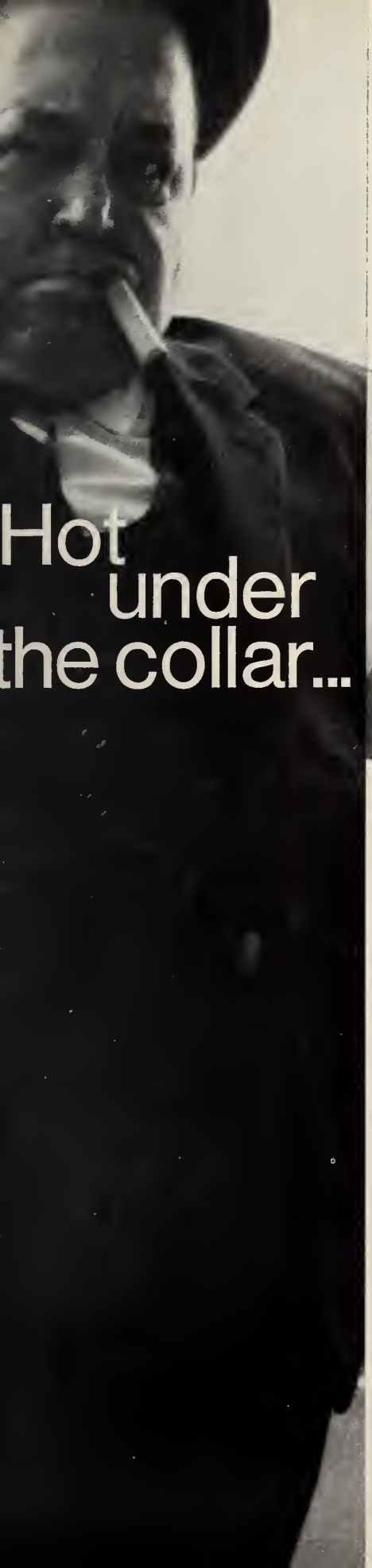
MILPATH®

(tridihexethyl chloride + meprobamate)

WALLACE PHARMACEUTICALS / Cranbury, N. J. 08512

See adjacent page for brief summary of prescribing information.





Hot
under
the collar...

high under
the cuff.

Sometimes
he forgets he has hypertension, gets hot
under the collar. . . high under the cuff.

For such
patients, consider **Regroton®**

chlorthalidone	50 mg.
reserpine U.S.P.	0.25 mg.

To lower blood pressure
and allay anxiety in hypertension.

For brief summary of prescribing information, see next page.

RE-6392

Regroton®

Geigy

chlorthalidone 50 mg.
reserpine U.S.P. 0.25 mg.

the once-a-day tablet for anxious hypertensives

Regroton is a combination of two basic antihypertensives designed to lower blood pressure and allay anxiety in hypertension. With Regroton he can keep his shirt on and you can keep his blood pressure down.

Before prescribing, please review carefully the indications, contraindications, warning, precautions, adverse reactions and dosage information below.

Regroton®
Each tablet contains:
chlorthalidone 50 mg.
reserpine U.S.P. 0.25 mg.

Indications: Hypertension.
Contraindications: History of mental depression, hypersensitivity, and most cases of severe renal or hepatic diseases.
Warning: With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small-bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has frequently been required and deaths have occurred. Discontinue coated potassium-containing formulations immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Discontinue one week before electroshock therapy, and if depression or peptic ulcer occurs.
Use in pregnancy: Because chlorthalidone may cross the placental barrier and appear in cord blood and thiazides may appear in breast milk, this drug should be used with care in pregnant patients and nursing mothers. When used in women of childbearing age, the potential benefits of the drug should be weighed against the possible hazards to the fetus. Use of chlorthalidone may result in fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult. Increased respiratory secretions, nasal congestion, cyanosis and anorexia may occur in infants born to reserpine-treated mothers.
Precautions: Antihypertensive therapy with this drug should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents, other potent antihypertensive drugs, or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. To avoid hypotension during surgery, discontinue therapy with this agent two weeks prior to elective surgical procedures. In emergency surgery, use, if needed, anticholinergic or adrenergic drugs or other supportive measures as indicated. Because of the possibility of progression of renal damage, periodic kidney function tests are indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated. Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, the drug should be discontinued and potassium supplements given, provided the patient does not have marked oliguria.
Take particular care in cirrhosis or severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Severe salt restriction is not recommended. Use cautiously in patients with ulcerative colitis or gallstones (biliary colic may be precipitated). Bronchial asthma may occur in susceptible patients.
Adverse Reactions: The drug is generally well tolerated. The most frequent side effects are nausea, gastric irritation, vomiting, diarrhea, constipation, muscle cramps, headache, dizziness and acute gout. Other potential side effects include angina pectoris, anxiety, depression, bradycardia and ectopic cardiac rhythms (especially when used with digitalis), drowsiness, dull sensorium, hyperglycemia and glycosuria, hyperuricemia, lassitude, restlessness, transient myopia, impotence or dysuria, orthostatic hypotension which may be potentiated when chlorthalidone is combined with alcohol, barbiturates or narcotics, leukopenia, aplastic anemia, skin rashes, thrombocytopenia, agranulocytosis, nasal stuffiness, increased gastric secretions, nightmare, purpura, urticaria, ecchymosis, weakness, uveitis, optic atrophy and glaucoma, and pruritus. Eruptions and/or flushing of the skin, a reversible paralysis agitans-like syndrome, blurred vision, conjunctival injection, increased susceptibility to colds, dyspnea, weight gain, decreased libido, dryness of the mouth, deafness, anorexia, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Jaundice, xanthopsia, paresthesia, photosensitization and necrotizing angiitis are possible.
Average Dosage: One tablet daily with breakfast.
Availability: Pink, single-scored tablets in bottles of 100 and 1000.
(B)46-600-C
For details, please see complete prescribing information.

Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York 10502

RE-6392

Doctor Who Saved 'Scottsboro Boy' Retiring As Censor

The narrow balcony that circled the high-ceilinged operating room of Hillman Hospital was crowded that day. And not all of the spectators were interns and medical students. Somehow a group of newspaper reporters had worked their way into the group.

For the brain surgery taking place beneath them was news, of the first magnitude.

The reporters of then failed to identify the masked and gowned chief surgeon, the assistant surgeon, the anesthetist, and the three nurses surrounding the unconscious figure on the table, strapped down securely to avoid any whisper of movement. They were merely "background material."

For the star of the show was none other than Ozie Powell.



Dr. W. S. Littlejohn with Chairman of the State Board of Censors, Dr. John M. Chenault, Decatur.

The world has forgotten Ozie now, but in that distant day, more than a third of a century ago, he had again made top headlines in *The New York Times*, the *Herald-Tribune*, the *World*, the *Daily News*, *The Chicago Tribune*, the *Los Angeles Times*, and almost any other newspaper that you'd care to name, including *The Birmingham News*, the *Age-Herald*, the *Post*, *The Mobile Item and Register*, the *Decatur Daily*, the *Huntsville Times*, *The Montgomery Advertiser*, the *Selma Times-Journal*.

Ozie was one of the nine so-called "Scottsboro boys," tried, convicted and condemned to die for the rape of two white women "hoboes" on a freight car. The International Labor Defense, a communist front organization with its New York attorney Samuel Leibowitz had brushed aside several world famous attorneys, including Clarence Darrow, to make a cause celebre of this case and harvest millions of dollars of free publicity in the process.

Ozie had distinguished himself earlier in the day by cutting the throat of Madison County Deputy Sheriff Edgar Blalock and getting, in return, a bullet in his head from the gun of Sheriff J. Street Sandlin.

It was Wednesday, Jan. 24, 1934. The bullet from the sheriff's gun had entered Powell's skull high in the forehead, at the hairline; had ranged backward and downward, penetrating a small section of the brain, and lodging in the back of the skull.

While spectators watched silently from the balcony above, a segment of Powell's skull was removed and the bullet lifted from where it was embedded. Just last year, a paperback book about the Scottsboro case carried a drawn illustration of the dramatic moment when Dr. Wilmot S. Littlejohn held aloft the retrieved pistol slug, while still standing across from him was his assistant, Dr. Benjamin F. Morton. Dr. Morton was then 29 years old, going on 30, and Dr. Littlejohn was two years his senior. Both are still prominent Birmingham physicians, specialists in the field of Psychiatry and Neurology.

Dr. Littlejohn, for 13 years a member of the State Board of Censors, will not stand for

reelection at the annual meeting in Huntsville.

A native of Cordele, Ga., son of a Circuit Judge, graduated from Emory in 1921, a member of Kappa Alpha social fraternity, Dr. Littlejohn was a "volunteer" in the Medical College of the University of Alabama, Birmingham (which "meant I worked for nothing"), and is today professor emeritus of the Department of Neurology, which he helped found. He is chairman of the committee that organized the first after-care program in Alabama.

He is married to the former Mary Rose Brown of Americus, Ga., who once remarked: "I have been a country doctor's wife, an intern's wife, a resident's wife, a specialist's wife, a navy wife and a professor's wife." Mrs. Littlejohn served for two years as editor of WAMASA, the Woman's Auxiliary publication.

They have one daughter, Mary McLester (Littlejohn) Belser, whose husband is an Auburn professor, and the Belsers have twin daughters. Mrs. Belser is presently completing work on her Ph. D. in English at Auburn.

Authoritative Voice Of Perry Mason Now Talks Medicine

The "Living Voice of Medicine" has been speaking to doctors all over the nation since Jan. 1st, sharing with individual practitioners the latest procedures in their field. And the voice is that of Perry Mason.

In what is hailed as an "information explosion," the American Medical Association has developed an Audio News Journal, a recorded informational service for the profession.

This is a once-a-month 65-minute tape recording highlighting current medical events throughout the world. Because demands on the physician's time are so great, the recorded informational service was envisioned as a practical means of permitting him to keep pace with medical developments by playing all or segments of a recording during "idle" or "unproductive" moments. The recordings are playable at home, in the office or in the car.

All coverage provided through the recorded news format of Audio News Journal is live. The informational service is not intended as a medium to provide verbal reporting of scientific papers or condensation of published medical news.

A wide variety of subject matter is covered on the tapes, but emphasis will be on-the-scene coverage of major medical meetings, new developments in the health field and interviews with health professionals and public figures on political, social and economic aspects of medicine.

Serving as anchorman for the news program is Raymond Burr, better known as television's "Ironside" or "Perry Mason." On-the-spot reporting is handled by a team of correspondents.

The AMA's Board of Trustees approved the concept last fall following more than a year of study by members of the AMA staff. A marketing study, including a questionnaire sent to physicians, indicated high interest in such a service.

Introduction of AMA's Audio News Journal marks the first time that such a professional association has developed a recorded informational service of this type for its total membership.

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effectiveness in mixed anxiety-depression

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Before prescribing or administering, see Sandoz literature for full product information, including adverse reactions reported with phenothiazines. The following is a brief precautionary statement.

Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.

Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when necessary.

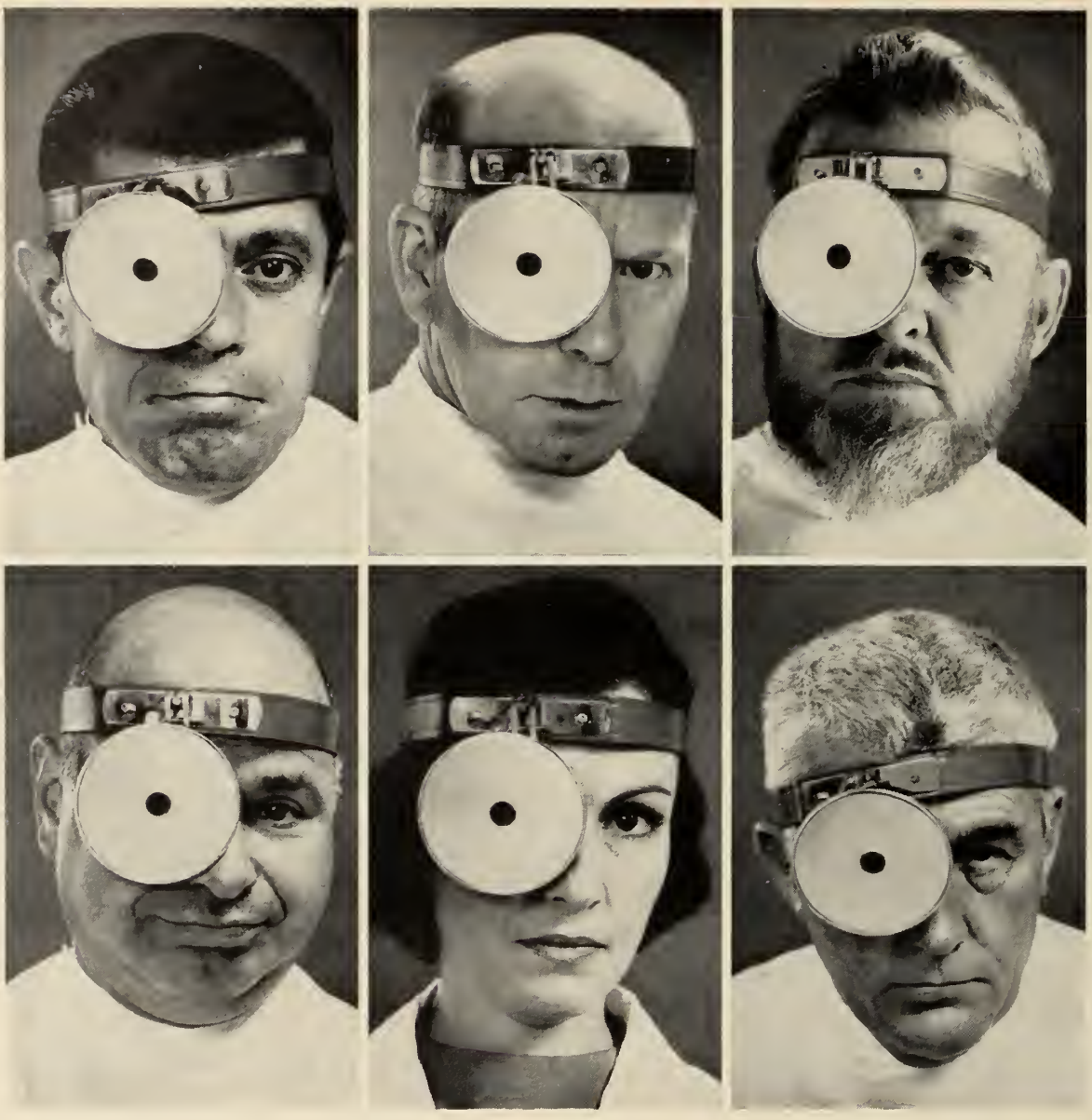
Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving). Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascular System*—Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers, including Mellaril (thioridazine hydrochloride). While there is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients previously showing electrocardiographic changes. The use of periodic electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. *Other*—A single case described as parotid swelling.

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You might also say that all otolaryngologists aren't alike, either.





Looking Forward With Hope, Backward With Regret

The long-sought cure for cancer today is where the unlocking secrets of atomic energy were in 1939, Dr. R. Lee Clark, president of the M. D. Anderson Hospital and Tumor Institute in Houston told Texas lawmakers recently.

"We're curing something over 40 per cent of our patients now—they're living longer," he said. "We're coming into the basic knowledge that will allow us to cure the problem."

But it may take longer than atomic energy, he warned, because "in unlocking the genetic code, we haven't got the tremendous opportunity to accelerate developments like the war provided for atomic energy."

* * *

The Houston hospital, one of only three such research institutions in the nation, was where the late Gov. Lurleen Wallace went for treatment. Funds are now being raised for a fourth such institution, a $15 million cancer research and treatment center in Alabama, to be named the Lurleen B. Wallace Memorial Hospital and Tumor Institute.

"And wouldn't it be wonderful," asked Gov. Albert Brewer, speaking in behalf of this institute, "if in Alabama the ultimate cure for cancer could be found?"

* * *

A mechanical heart will substitute for the uncertain human transplant within the next two decades, Dr. Michael E. De Bakey predicted recently in a special article written for Science Service:—"an artificial heart that will enable us to save thousands of lives yearly, instead of the few scores we are now prolonging by transplantation."

More than that, Dr. De Bakey, internationally famous in the field of heart transplants, and whose brother, Dr. Ernest G. De Bakey, a specialist in thoracic surgery, practices in Mobile, is "equally convinced that ultimately we shall perfect preventive measures that will insure healthy hearts to a ripe old age."

* * *

There are very few "thalidomide babies" in the United States—babies born without arms or with only stumps for arms—thanks to the refusal of the U. S. Food and Drug Administration to license the drug. But there are more than 6,000 in the rest of the world, more than a third of them in Germany.

A widely published feature story of some weeks ago described a group of these armless children trying to learn to ski in Alsdorf, West Germany—in high good humor tumbling, recovering, and tumbling again.

These children are 8 and 9 years old now. Litigation is still in the courts with every prospect of remaining there for a long time. There has been no compensation paid to the children's families.

Thalidomide was a drug taken by pregnant mothers to promote sleep. It was taken off the European market after the first examples of the birth defects it caused.

VIENNA MEDICAL TOUR

Vienna's illustrious history in medicine and scientific progress has stirred widespread interest. In answer to wide demand, a new sightseeing tour of Vienna's medical highlights will carry to through the Museum of Medical Sciences, and to the sites connected with some of Austria's pioneering physicians: Karl Landsteiner, who discovered blood types; Clemens von Pirquet, who devised the tuberculin and pioneered allergy research; Julius von Wagner-Jauregg and Sigmund Freud, of psychiatric fame; Guido Holzknecht, Theodor Billroth, Ignaz Semmelweis, and others.



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Renal Transplantation at the University of Alabama Medical Center*

Arnold G. Diethelm, M. D.**

Renal transplantation was performed for the first time at the University of Alabama Medical Center in May of 1968. This procedure, the result of 12 months of organization by the Departments of Medicine and Surgery, was the initiation of the Medical Center into the field of organ transplantation. Four patients receiving kidneys from related living donors are at present living and well with normal or near normal renal function one to eight months post-transplantation. A fifth patient, receiving a cadaver kidney, rejected the transplant in eight days in a hyperacute fashion. The rejected kidney was removed and the patient is now on maintenance dialysis awaiting another transplant.

Recent data from the sixth Kidney Transplant Registry indicates that 78 percent of the recipient patients receiving kidneys from sibling donors are now surviving after one year, with some transplant centers approaching 90 percent survival. Transplants from parent to offspring, in general, have a 72 percent one year survival, and approximately 45 percent of cadaver transplants are surviving after one year. From these results it is apparent that renal transplantation now provides an acceptable therapeutic approach to select patients with terminal chronic renal failure.

The purpose of this paper is to present a brief outline of the organizational structure of the renal transplant program, the methods of evaluation for the donor and recipient patients, a review of the current development of tissue typing at the University of Alabama Medical Center and a brief mention of the immunosuppressive therapy used for the management of these patients.

Organizatien of the Renal Transplant Program

The renal transplant program is a combined medical-surgical unit in the University of Alabama Medical Center, located on the Surgical Service of the Veteran's Administration Hospital. The approval of the Sharing Agreement Act by Congress has enabled the University Hospital and the Veteran's Administration Hospital to participate actively in exchange of patients. This means that non-veteran patients can be treated at the Veteran's Administration Hospital with special procedures which are unavailable at the University Hospital, and patients from

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the Veteran's Administration Hospital can undergo treatment at the University Hospital for certain diseases. Therefore, the transplant program located within the Veteran's Administration Hospital is able to care for both veteran and non-veteran patients.

Certain features are necessary prior to the development of a renal transplant program. These are: 1) a well-equipped, active transplantation research laboratory capable of investigating clinical and experimental problems relating to transplantation biology, 2) a surgical team for the management of both the donor and recipient patient, 3) a renal dialysis program capable of handling acute and chronic renal failure with adequate facilities and personnel to support patients pre- and post-transplantation, 4) a medical team trained in the complex problems relating to post-transplant complications, such as infectious diseases and severe hypertension refractory to the usual antihypertensive medication, 5) a follow-up clinic staffed by Medicine and Surgery for the care of post-transplant patients. An organizational development such as described implies a truly interdepartmental program involving Medicine, Surgery, Urology, Pediatrics, Pathology, Clinical Pathology and Radiology. The progress of organ transplantation depends upon the total effort integrated into the program by the Medical Center.

Patient Selection

Patients evaluated for renal transplantation clearly should have reached the terminal phase of chronic renal failure. Some of the common etiologic factors leading to renal failure are outlined in Table I. Such a patient, having been treated by the usual conservative measures available for the treatment of chronic renal failure, becomes a candidate for evaluation for either chronic dialysis or transplantation (Table II). The patient should be somewhere between five and 50 years of age, although patients as young as three and beyond the age of 70 have undergone renal transplantation. The basic renal disease should be clearly irreversible and the

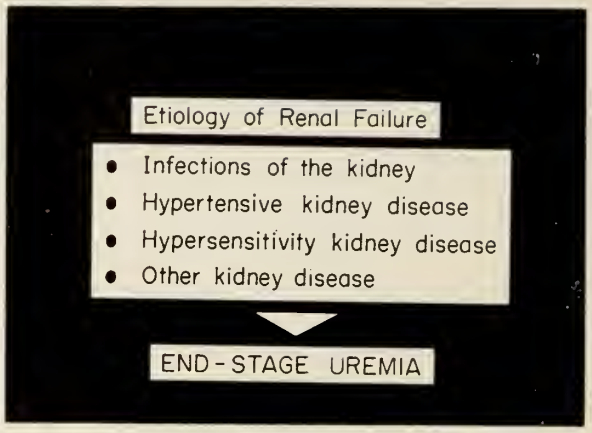


TABLE I

patient should have a normal lower urinary tract, or else pathology that can be surgically remedied. There should be no major extrarenal complications, such as severe cerebral or coronary artery disease. Patients with far advanced renal failure who are bedridden with severe neuropathy, malnutrition, pancytopenia, infection or ileofemoral occlusive disease are usually not suitable candidates. Active progressive glomerulonephritis is, in general, a discouraging problem with which to deal by transplantation. The complicating feature in this instance is the transmission of the original disease to the transplanted kidney. The exact incidence of glomerulonephritis occurring in the transplant is unclear but appears to be more frequent in those patients with active glomerulonephritis of short duration.

In order to obtain a standard amount of information, a form has been devised for pros-

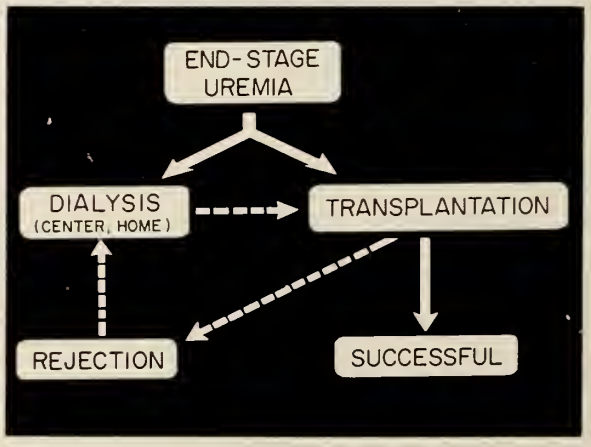


TABLE II

pective recipient diagnostic evaluation prior to admission, or within the hospital. The form is similar to that used by the Peter Bent Brigham Hospital, Boston, Massachusetts (see Table III).

After review of the collected data, the patient is evaluated by the medical-surgical team of the transplant unit. If the patient is found to be a suitable candidate for a transplant, the question of a proper donor is explored. The donor for the recipient patient may be either a living related donor or a recently deceased unrelated patient. If the transplant is to be from a living related donor, a relative willing to donate a kidney is interviewed by a member of the transplant team separate from those caring for the recipient patient. This interview allows that physician to be completely objective in his evaluation of the donor patient. If the donor appears to be well-motivated in his reasons to donate the kidney and by history and physical examination appears to be in good health, certain specific laboratory tests are required prior to his acceptance as a transplant donor. These tests include a normal urinalysis, complete blood count, blood urea nitrogen, creatinine, fasting blood sugar, uric acid and urine culture. An intravenous pyelogram and two creatinine clearances must be within normal limits. (A form similar to the recipient form is used for data collection evaluating potential donor candidates). The results of these tests being satisfactory, the patient is admitted to the University Hospital or the Birmingham Veteran's Administration Hospital for a renal arteriogram to determine whether single or multiple arteries supply the kidneys. If both kidneys are normal with a single renal artery and there is no reason to select one kidney over the other, as a general rule, the left kidney is used as the donor kidney. At this point, a commitment is made by the transplant surgeon to the recipient patient that the Department of Surgery at the University of Alabama will accept that patient as a candidate on the renal transplant program. Because of limitation of space and money, a similar commitment cannot be made to carry the patient on chronic dialysis at the present time.

Preparation of the Recipient Patient for Transplantation

Once the patient has been accepted for transplantation, intermittent hemodialysis is begun through an indwelling arterial venous shunt placed in the forearm. The number of dialyses necessary depends upon the advanced degree of the patient's chronic renal failure and the rapidity with which the patient responds to the point where his physical and mental condition are satisfactory so that a bilateral nephrectomy can be performed. The nephrectomy is usually done 14 to 21 days prior to transplantation in order to reduce the difficulty in coping with hypertension and to allow the patient to recover from the surgical procedure.

Surgical Procedure of Renal Transplantation

In the case of a transplant from a living donor to the recipient, the two operative procedures are performed simultaneously in adjacent operating rooms. The isolation and preparation of the donor kidney is performed by one surgical team while the recipient is being prepared by a separate team of surgeons. The operative incision for the transplant involves an oblique incision in the right lower quadrant, utilizing an extraperitoneal approach. The iliac artery and vein are identified; the hypogastric artery is dissected free to the point where it divides and is then ligated distally, divided and used as the anastomotic vessel for the renal artery. The iliac vein is prepared for an end-to-side anastomosis to the renal vein. After the donor and recipient surgical teams are prepared, the kidney is removed from the donor patient and perfused for three to four minutes with a heparinized solution of Ringers Lactate with a pH of 7.4 at 4°C with one per cent procaine. This allows chilling of the kidney thereby decreasing the effects of the ischemic interval and removing all of the donor red blood cells within the kidney parenchyma. After completion of the perfusion, the kidney

TABLE III

FORM FOR PROSPECTIVE RECIPIENT WORK-UP PRIOR TO ADMISSION

NAME: _____ AGE: _____ SEX: _____

Address: _____

Relationship to Proposed Donor: (if any) _____

Pertinent Medical History: _____

_____

Pertinent Physical Findings: _____

_____

Urinalysis X 3: _____ pH: _____ Protein Glucose _____

S. G.: _____ HCT: _____ WBC _____

Microscopic: _____ Differential: _____

Chemistry: Urea Nitrogen: _____ Sodium: _____

Cholesterol: _____ Potassium: _____

Fasting Blood Sugar: _____ CO_2 _____

Uric Acid: _____ Chloride: _____

Urine Culture X 2: 1. _____ 2. _____

Tissue Type: _____ Blood Type: _____

Chest X-ray: _____

EKG: _____

Consultations and Special Slides	Date	Results
Urologic Evaluation (including cystocopy and retrogrades, cystogram, cystometrograms as indicated).		
Medical Evaluation (Re: Activity of disease, presence or absence of systemic disease, i.e. Lupus, hyperparathyroid, etc.)		

Comments: _____

is taken to the adjacent operating room and the renal artery-hypogastric artery and renal vein-iliac vein anastomoses are performed. Following completion of these two anastomoses, the vascular clamps are removed and blood allowed to circulate through the kidney. The ureter is then implanted into the bladder, using a tunnel technique, and, with the exception of a foley catheter inserted preoperatively per urethra, no nephrostomy or ureteral catheters are used. The operative incision is closed in layers with silk sutures. Following surgery, the patient is taken to the recovery room and then to the transplant unit where a suite of two rooms are specially constructed to maintain a minimal amount of bacterial contamination. This area is located on the Surgical Service at the Veteran's Administration Hospital. Patients remain in these rooms for 10 to 14 days and when incisions are healed and the immunosuppressive drug dosage reduced, they are returned to the surgical ward.

In the case of cadaver donors, the relatives of the patient who has sustained an irreversible injury are contacted by a member of the transplant team. The situation is carefully explained to them and if the relatives agree, the kidneys of the critically ill patient will be used for transplantation, in the event that the patient expires. The care of the acutely ill potential donor patient is completely under the physicians caring for that patient, and the transplant physicians remove themselves from the scene until they are notified that the patient has expired. The determination of death is verified by two non-transplant physicians utilizing criteria of respiration, heart sounds, electrocardiogram and electroencephalography. After the patient has been pronounced dead and the authorization for removal of the kidneys has been obtained from the next of kin, the body is taken to the operating room where the kidneys are removed by a separate operative team under sterile conditions. Because of the prolonged time interval between the procurement of the cadaver kidneys and the completion of the transplant procedure, the kidneys are maintained at 4°C in a Ringers Lactate solution with a pH of 7.4. The upper limit of time for the storage period under these conditions is usually between three and four hours. Therefore, the vascular anastomosis needs to be completed within this period of time.

Post-Transplant Course

The post-transplant course may be relatively unremarkable or develop into a series of complicated events. Urine output of transplants between living donors and recipients is usually immediate, although kidneys obtained from cadavers often undergo a transient period of acute tubular necrosis with oliguria or anuria for variable periods of time. During periods of anuria, dialysis is necessary and facilities for this are available in the transplant suite.

The medications used in the post-transplant course are azathioprine, prednisone and actinomycin C. Azathioprine, a derivative of 6-mercaptopurine, is the primary immunosuppressive agent and is administered in varying dosages between 2 to 5 mg/kg/day. The exact dosage depends upon the function of the kidney as determined by daily determinations of blood urea nitrogen and creatinine, and the white blood cell count reflecting the toxicity of the drug upon the bone marrow. Prednisone is also used, with the initial dosage of 2 mg/kg/day rapidly decreased to lesser amounts. Both drugs are gradually tapered according to the white blood cell count and the renal function for the first three to four weeks post-transplantation, at which time the drug dosage is usually in the neighborhood of 1 to 2 mg/kg/day of azathioprine and 1 mg/kg/day of prednisone.

If rejection occurs in the post-transplant course, reversal is usually achieved by an increase in prednisone to 400 mg per day for 48 hours, with gradual reduction to a more tolerable level. Actinomycin C, given intravenously in individual injections of 4 to 8 micrograms per kilogram per day, is very effective in a 3 to 5 day course. Three separate

doses of X-ray therapy, 150 r in air, are also given to the renal transplant during acute rejection.

The recent addition of antilymphocyte sera provides additional support to the previous immunosuppressive regimen. The serum, prepared in the research laboratories of the Department of Surgery by injecting thymus tissue into horses, produces an antibody shown to be a most effective immunosuppressive agent in canine and human renal allografts. Antilymphocyte serum is not currently available on the commercial market and, therefore, must be made by the individual laboratory involved in organ transplantation.

The usual hospital stay for the kidney transplant patient is between six and ten weeks, depending upon the post-transplant course and the distance from the patient's home to the University Medical Center. During the hospital course the patient is allowed to go home for varying periods of time, increasing in duration, until final discharge. Follow-up care is under the direction of the Medical and Surgical personnel of the renal transplant unit. As the number of transplanted patients increases, it is expected that physicians throughout the state will become acquainted with the management of these patients and, in many instances, the patients can be managed by their private physicians in consultation with the transplant staff.

Tissue Typing

A tissue typing laboratory has been organized under the direction of Dr. June Shaw in the Department of Clinical Pathology, University of Alabama Medical Center. Dr. Shaw, a full time member of the Department of Clinical Pathology, has undertaken to develop this program with support of the New York Blood Center in New York City.

Histocompatibility testing ("tissue typing") is the method by which a prospective donor-recipient pair is evaluated for similarity in tissue antigens. These donor-recipient evaluations are performed prior to transplantation. The rejection of transplanted organs is an immunological process in which the recipient reacts defensively against donor tissue, causing dysfunction and death of the transplanted organ.

In renal homograft rejection, there are antigens on or in the transplanted kidney cells which are not present in the recipient cells. The immunologically competent cells (lymphocytes) of the recipient recognize these "foreign" antigens as not being identical to his own antigens and antibodies are formed to the "foreign" antigens by the recipient. These antibodies then react (through an unknown mechanism) with the antigens on the donated kidney, resulting in destruction of the transplanted kidney.

Theoretically, if the antigens in the donor were identical to the antigens in the recipient, as is the case in identical twins, the transplanted organ should survive and function indefinitely. Therefore, with a high degree of similarity in antigenic composition in a donor-recipient pair, a transplanted organ should, and does, have a longer survival and better function.

The Tissue Typing Laboratory is currently employing the lymphocytotoxicity test as the preferred method of histocompatibility testing. This test is based on the principle that if a serum which contains a specific antibody is incubated with a cell which possesses the complementary antigen, an antigen-antibody reaction will take place and will cause injury and loss of viability of the cell. A suspension of lymphocytes containing antigens thought to be identical to the kidney antigens is obtained from the patient as the antigen source. These lymphocytes are then mixed with a panel of antisera which contains antibodies of known specificity. In this fashion, the antigenic make-up of the prospective recipient can be ascertained. A lymphocyte suspension from the prospective donor is obtained and tested against the same panel of antisera. The donor and recipient are then evaluated as to antigenic disparity.

At the present time, histocompatibility testing is done for eight different tissue antigens. These are called the transplantation antigens and have been named H-LA 1 through H-LA 8. A major mismatch is present if the donor has a specific antigen which the recipient lacks; a minor mismatch is present if the recipient has a specific antigen which the donor lacks. The similarity or disparity of antigens is ranked on an A through F scale. An "A" match is identical antigenic composition between donor and recipient; an "F" match is a positive cross-match which indicates the recipient has humoral antibodies to donor lymphocytes. There are gradations of compatibility between "A" and "F". An "A" match between donor and recipient would be ideal in all transplants, whereas, an "F" match is a contraindication to transplantation between a donor-recipient pair. Although false positive and false negative reactions occur in tissue typing, the long-term survival of renal transplants generally parallels a favorable tissue match.

Summary

Renal transplantation has become an increasingly effective method of managing a select group of patients with terminal renal failure.

Data from the Kidney Registry indicates that approximately 78 percent of patients receiving kidneys from siblings have a functioning transplant one year later and in certain transplant centers these figures approach 90 percent.

The use of tissue typing and antilymphocyte globulin, improving the selection of patients and their immunosuppressive management, has contributed significantly to these results.

Immediate plans for the next two years are to gradually increase the number of renal transplants performed at the University of Alabama Medical Center, depending upon the number of patients requiring transplantation and the medical facilities available to handle the patient needs.

Theory, Learning And Origin Of Complexes

Wallace Marshall, M. D.

Montgomery, Alabama

There is decided interest currently in education and its possible upgrading. Learning forms the basis for education. Appropriate learning techniques of a practical and a more scientific nature are being suggested. However, it might be preferable if adequate learning theories, backed by scientific investigation, might be employed to help with this difficult task. A learning theory which might explain both normal and abnormal behavior perhaps might be a decided boon. It might be preferable if such were biologically oriented so that the multidisciplines, which have to do with these learning procedures, could employ similar terminologies. Perhaps much mysticism, presently associated with the psychodynamic approaches, might disappear and thereby clear up these muddy waters which involve the human "mind."

Education, per se, should not be regarded as a complete panacea for all of mankind's problems, any more than psychiatry can be expected to eradicate all behavioral illnesses. Such emotionally provoked reactions as lust, hostility, greed, and a host of other antisocial reactions, might be rechanneled to more socially acceptable lines, although the results from undesired human emotions have plagued mankind since his genesis and perhaps will continue so long as the human race exists. It is asking too much from education to completely change such untoward emotional reactions.

It might be expedient to review what are known as hypotheses, theories and laws. One should know what can be expected from them. Equipped with this information, one may be in a much stronger position to discuss such topics intelligently.

Our knowledge of the molecular approach to learning, memory and thinking is rather new. Few adequate scientific studies were available merely ten years ago. My next paper will mention some of these highly interesting findings from the immunologic, neurophysiologic and biochemical sources in their attempts to unravel the mysteries of the brain's functionings, which are enshrouded presently in psychodynamic theories.

One distinguished psychiatrist[2] believes that fundamental investigations should be distinguished from clinical procedures, since the former have not as yet proven practical for the latter field. Perhaps this viewpoint is due to the lack of a suitable molecular theory for learning which can be applied to clinical psychiatry. One of the present tasks of this writer will be to present the psychoallergic approach to explain certain clinical subjects biologically.

Hence, it seems proper to presently consider what a theory, hypothesis or law is and what such should be expected from it.

The term science is defined by Dorland[3] as an "accumulating body of knowledge, especially that which seeks to establish general laws connecting a number of particular facts." Pure science is "concerned with the discovery of known laws relating to particular facts," while a law is defined as "a constant fact or principle."[4]

A theory[5] is defined as a speculation or

even a contemplation or an analysis of a certain set of facts related to each other. Furthermore, such facts can be either pure or applied. It should be plausible to at least incorporate an acceptable general principle to explain a certain train of events in a systematic, clear and sensible manner.

Braithwaite[6] states that a science functions by formulating the behavior of empirical events which concern science and connect them so that the prediction of events can be formulated. This same authority states that a hypothesis is "a general proposition about all the things of a certain sort."[7] He thinks of an hypothesis as being of empirical nature which can be tested by experience; if such happens to be true, it is a scientific law. The reader is referred to Braithwaite's book for a fuller discussion of this philosophical approach to a true theory based upon the use of common sense and adequate reasoning.

Many scientists believe the simpler the theory, the stronger it may be. Given a theory based on multiple tenets, compared to one based upon simplicity, most workers will favor the latter. All are concerned with data supplied from scientific investigations to explain some principle or principles which operate naturally. A hypothesis implies the lack of enough evidence; therefore, it is merely a tentative explanation. A theory implies a much stronger accumulation of evidence. Therefore, it is stronger than a hypothesis, since it implies greater probability of being truthful.

A law refers to a proposition which is well regulated to nature and which does not vary under a controlled set of conditions or events. These three states of formulary approach to a problem can be in flux, and the addition of new evidence can shift the status and strength of each approach.

Just where the concept of psychoallergy stands presently cannot be stated with accuracy, since it is relatively a new concept. A great deal of work is needed to classify its status properly. Hence the author has used the term of theory rather loosely at this time.

To hypothecate a belief or a certain formula, it is necessary to have some facts and then to treat them as if these were true. The investigator desires to discover the different relations between the facts he has derived from observation and those which he desires to uncover through further work with those clues which are available. His hypothesis need not necessarily be composed of observable facts, but the data certainly should have been gleaned from scientific observation. Hence, his deduced facts must be capable of standing scientific scrutiny. If these so-called facts are found wanting, then the hypothesis must be either changed or discarded after proper scientific investigation with the application of logic. If the results are not logical they are faulty in some manner.

Theories have been known to have been associated with speculation of an unverified nature. Moreover, these theories may be intimately associated with hypotheses, confirmed or not confirmed. These may even become scientific doctrines derived from a group of propositions. However, such should be systematic and thus employed as postulates resulting from one's intensive experience. These are then employed as scientific principles. Deductive theory evolves as an important tool for testing such beliefs. Hence, epistomology evolves as the science of the method employed and the grounds for the knowledge thus obtained with reference to its limits and its validity.[8]

The basis of theory is predicated on facts which come from observation. The tenets of such a theory are then open to test to determine the validity of the theoretical structure. The main reason for testing this structure or system is to be able to predict certain events and to understand the real *modus operandi* behind the theoretical structure, in order to determine the whys and wherefores. Hence, a theory consists of the

explanation of facts derived from scientific observations.

As Wolman[9] so aptly wrote, various criteria are needed for the credence of any scientific theory. He wrote about the necessity for "imminent truth." Thus, a scientific theory should not contain contradictions to the theory's main propositions. Furthermore, no contradictions should have arisen from experimental facts. Of exceptional importance is that scientific research must be based mainly upon the "discovery of truth."

Empirical events are employed to establish certain scientific laws. These separate events can be connected together so that reliable predictions can be formulated for presently unknown situations. This is common for the natural sciences, which are composed of the biologic and physical sciences. They contain empirical subject matter and are exemplified by anthropology, psychology, sociology and economics, and they should certainly include the study of mankind and his place in his natural environment.

George Engel[10] commented that psychological phenomena should not have the terminology and the techniques of biochemistry applied to it. He argued for incorporating knowledge gleaned from such sciences to develop a comprehensive theory for psychology and behavior. However, he did not believe the problems of the "mind" would be solved by biochemical means alone. He did not think that psychologic science's development would become superfluous because of biochemical discoveries. He did stress that biologic knowledge was needed to further psychological knowledge.

Engel's approach is more oriented toward science than those of the strict Freudian, the neo-Freudian or the more generalized psychodyanic schools. The construction of their theories are not usually founded upon a system used by pure science. The terminology they employ is certainly not used in the other sciences.

Bailey[11] wrote that Freud, at one phase of his career, tried to formulate an outline for scientific psychology which he termed "The Project," which was published. However, insufficient scientific data concerning neuro-physiology caused Freud to abandon this approach. According to Bailey, this impasse' forced Freud to begin his visionary psychologic speculations.

Concerning such psychologic speculations, Thigpen and Cleckley[12] called attention to many of the astonishing pronouncements made by Freud which were produced through mere assumption and analogy. As Bailey put it[13]: "The supreme achievement of Sigmund Freud could be epitomized as his feat of inducing the world to accept his conclusions without permitting observation of his methods of rendering an account of his results." In the following paragraph Bailey wrote: "Psychoanalytic data are not reliable and repeatable, hence not scientific, and later on (p. 90) "Because of its method, psychoanalysis will forever remain bad science." Sidney Hook and others echoed a similar belief.

We arrive now at the concepts which have to do with analogy. Recently, during a lecture in philosophy, the professor commented that most if not all arguments are based, in the long run, on comparisons or analogies which are also rife in the world's literature.

Webster[14] wrote about several types of analogies which are based upon the relationship of likenesses of one thing to another concerning the attributes, circumstances or effects of each. Biologically speaking, an analogy is concerned with a correspondence in function between organs or parts of different function and origin. Logically, so wrote Webster, an analogy is a form of inference that, if several things agree with each other in one or several respects, they will probably agree in still other ways.

Such a process is employed in almost every human endeavor, because any act whatsoever is usually compared with similar happenings. Even our common, daily language habits contain analogous metaphors, in which one object or idea is employed in place of another by denoting a likeness between them,

as with the use of a trope, simile or comparison. In science we compare abnorms with norms. This has become routine.

The interpretation of data uses analogy in order to compare one's present results with those obtained previously by one or more observers, either by the same experimenter or by different persons. This really constitutes the basis for controlled studies. Hence, it appears unfounded to condemn any theory merely because it happens to argue through analogy. But this is not the important point. The crux of the matter lies in the source of the experiment or theory and whether or not it was performed according to accepted scientific procedures.

One investigator may produce a thoroughly logical set of scientific data. His procedure may have been rendered in the best of scientific tradition. Few will probably question his findings as to its veracity when these were attained from well controlled studies.

The trouble lies in their interpretation which involves this pesky matter known as the analogical approach, for two well indoctrinated, well-trained scientists and even logicians, as a matter of fact, might arrive at two or more divergent views. Hence, it is the matter of interpreting scientific data which produces no little confusion.

Most if not all theories use analogy in formulating their own *modus operandi*. This is no indictment to good theory formation. However, such theories must have been founded on a scientific approach with the use of adequate controls and of similar importance, good sound logic must have been employed to formulate both the theory and the results obtained therefrom.

There appears to be a ridiculous trend these days whenever students, residents or graduate students wish to contribute their own beliefs while attacking or criticizing a theory. This takes the form of a game which is strongly reminiscent of the current television game called "Jeopardy." In this TV program, all answers are given in the form of questions. With the students who discuss theoretical concepts also in the form of questions, one wonders why such a ritual is followed. Our only rationalization concerning this silly bit of decorum is that, by asking a question, one does not run the risk of differing with his learned teacher. Therefore, he does not incur the chance of receiving a poor grade.

Obviously, mature teachers and their students should avoid this ridiculous ceremonial by meeting whatever challenges which are presented head on and by letting "the quips fall where they may"! In other words, a sound theory should be able to stand on its own two feet without ceremonials to protect it against injury. But, on the other hand, dissident teachers, who have little if any constructive worth in their arguments for or against theories can be called by what Prof. Magidoff* labeled as "superfluous men." Perhaps there are superfluous teachers and scientists. Arguments solely for the sake of further non-constructive ambigious statements add little value to the understanding of a theory's functionings. As this author[15] wrote sometime ago, "it is not a too difficult task to learn what others have written in our behalf. It is much harder to put our imagination and initiative to work at least to attempt to reward medical science for the wealth of information which others have given to us. We all tend to take too much for granted, and most of us as physicians, are too critical of the work of others but not too productive as we ourselves are concerned."

In an earlier paper[16], stress was placed on the brain sensitizations produced by one's environment. The sensitization-producing afferent stimuli are termed psychoallergens, which cause learning if one's neurologic pathways and input cortical centers function normally. Learning takes place because of the neurophysiochemical changes which are

* In his lectures on Eugene Onegen, CBS-TV, 1967 originating from New York University.

caused by the action of psychoallergens upon the afferent neural receptors in the cerebral cortex.

Overlearning can be regarded as the result from excessive psychoallergens which produce overstimulation of the brain's recording centers. In effect, such is a hypersensitization reaction. It follows that the realm between normal and abnormal learning processes is not abysmal.

Freudian *complexes* can be considered as being hypersensitive states of learning which resulted from the effects from overstimulation (overlearning). The psychoanalytic type of therapy reintroduces these stored (sub-conscious) results from learning as the analyst directs their reintroduction. This therapy resembles that employed by the allergist who produces immunity to allergens by very slowly introducing the offending allergen into the patient's body. In either case, too rapid introductions and or too strong doses of the offending agent may produce a surménage of undesired reactions. With the allergist, his patient may exhibit a severe allergic reaction, while with the analyst, a severe psychiatric reaction may ensue in the form of a severe depression or a suicidal attempt in his patient. Hence, both physicians must remain continually alert for such untoward reactions. As was mentioned previously, the Wier-Mitchell "rest cure" removes both types of patients from their irritating environments. The psychiatric patient is removed from further irritations from psychoallergens which produced his overlearning in the form of complexes; the allergic patient is removed from antigens which produced his form of allergic response, be it urticarial, an attack of asthma or what not.

Along similar lines, the detection of psychologic complexes is discovered through the use of association tests which introduce key words (visual psychoallergens) which produce observable emotional reactions in a sensitized patient to related concepts. Similarly, the Rorschach test employs visual psychoallergens which can set off similar emotional reactions in a subject who has been previously sensitized to similar types of overlearning.

Sensory deprivations obviously decrease learning responses, while added combinations of sensory perceptions and their neural tracts bring added associated afferent neural stimuli to the recording centers of the brain. This is the basis for the Montessori teaching methods which use reinforcing psychoallergens to teach pupils, as with the aid of tactual stimuli, vision and hearing. Perhaps the case of this state's Helen Keller is a case in point. She was born without the use of vision and audition. Yet she was able to learn (sensitize the brain) merely with the use of her remaining afferent neural tracts which had to do with her touch and olfactory tracts.[17]

Fuller[18] studied the behavior of dogs under various aspects of deprivation of sensory stimuli (environmental). He found that deprivation does not necessarily prevent normal development of intelligent behavior, but it interferes with behavior in vulnerable dogs. After isolation the perceptual stimuli were overwhelming. Also, genetic factors appeared to enter into the animals' reactions. Permanent retardation was a possibility. These findings appear to support the situation with Helen Keller's disabilities. So the lack of perception at birth in the human, who is devoid of all 5 afferent neural tracts, might well result in complete amentia.

Important as education is, if all students earned their doctorate degrees, who would remain to do the repair work? Learning and education are not the final answers for all of mankind's dilemmas. Perhaps it is fortunate that nature maintains its own checks and balances. The revered Milton summed it all when he wrote:

> Accuse not Nature;
> She hath done her part.
> Do thou but thine!

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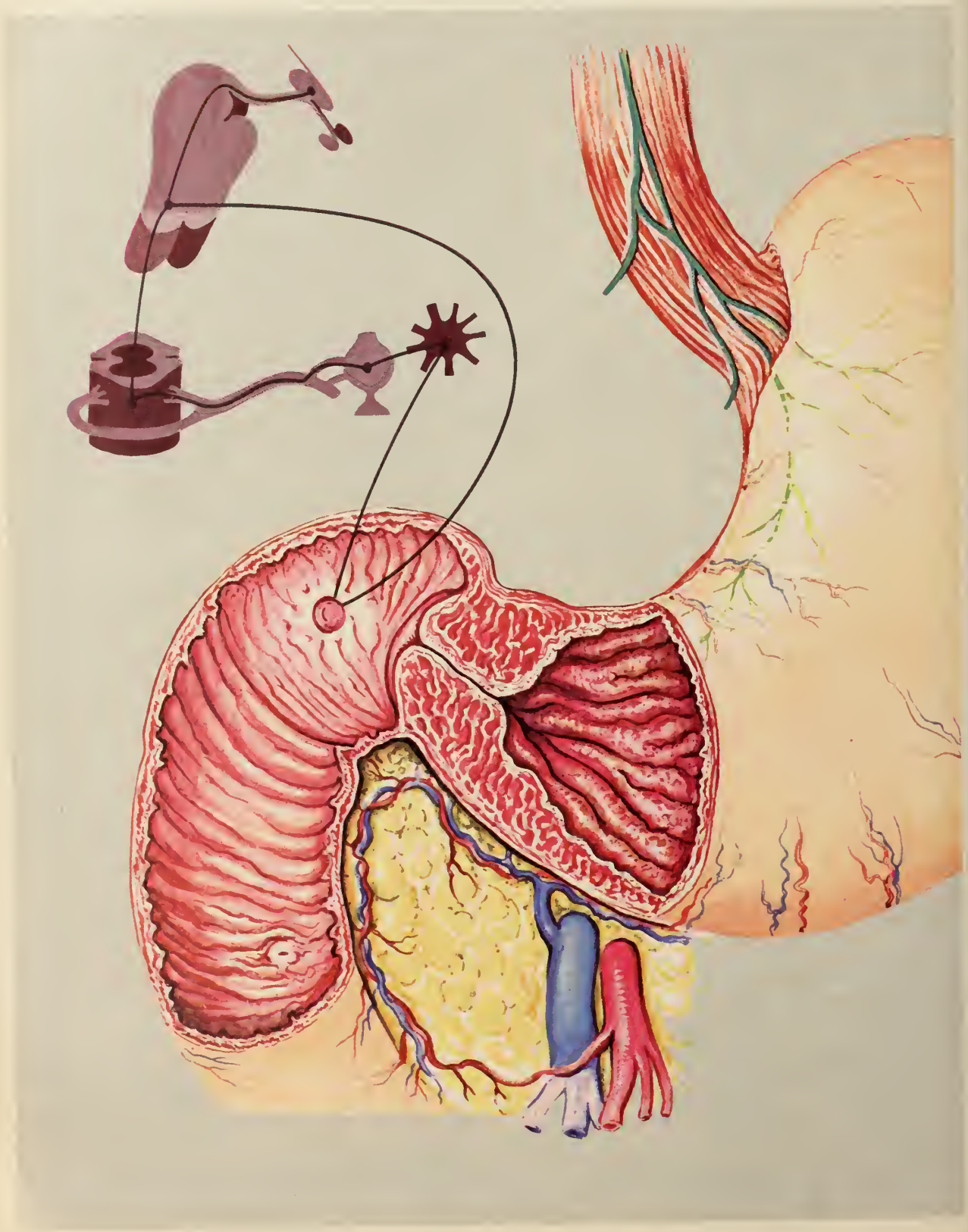
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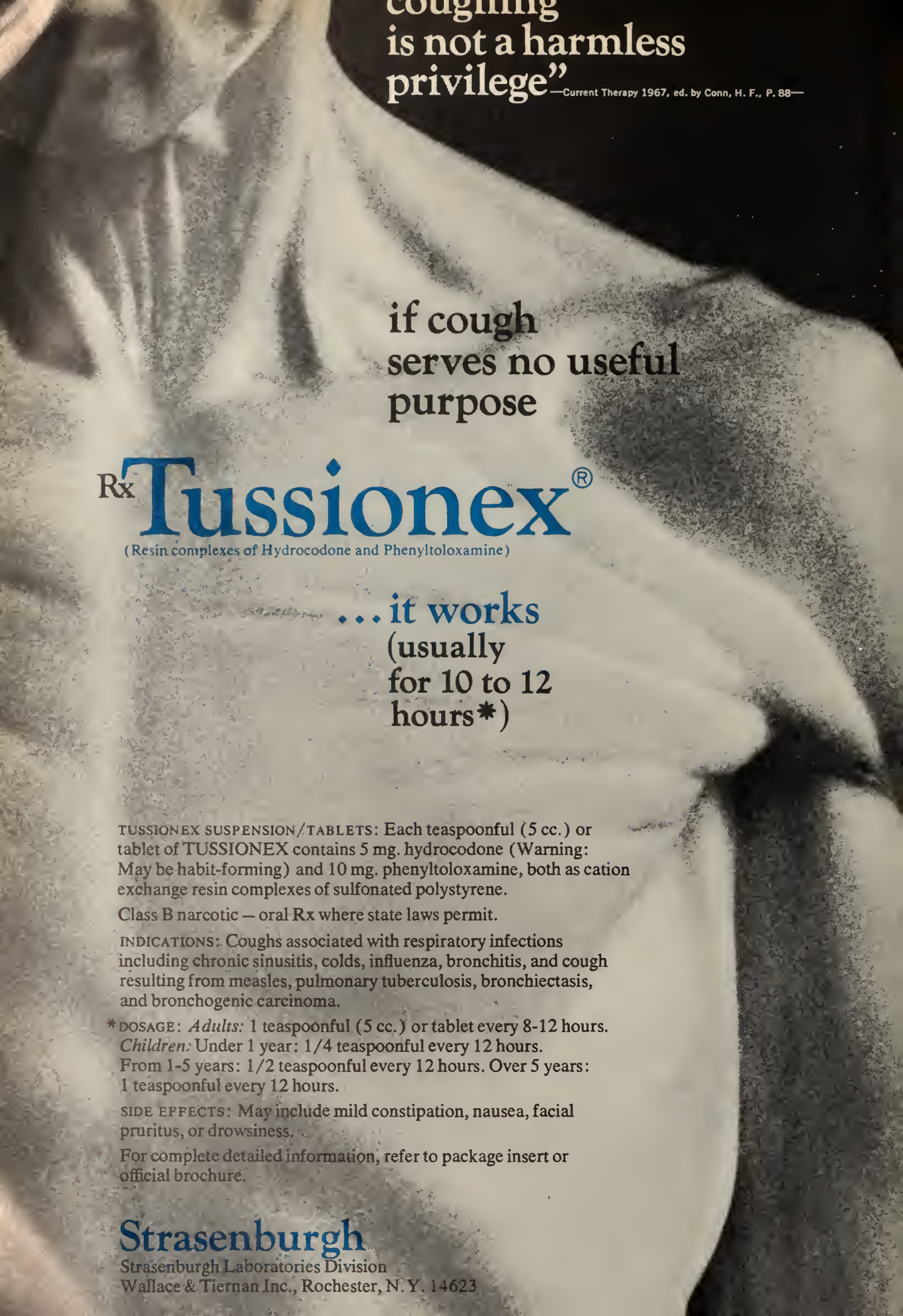
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Program

of the

108th ANNUAL SESSION

of the

MEDICAL ASSOCIATION OF THE STATE OF ALABAMA

CARRIAGE INN MOTOR HOTEL — HUNTSVILLE

APRIL 24, 25, 26, 1969

The 108th Annual Session of the Medical Association of the State of Alabama will convene at 9 A. M. on Thursday, April 24, 1969, in the Ballroom of the Carriage Inn Motor Hotel in Huntsville, Alabama.

The opening session will be called to order by E. L. McCafferty, Jr., M. D., President of the Association. It will be followed immediately by the Orientation Program for new members with Kermit Pitt, M. D., President-Elect, presiding. Theme of the Orientation Program is "Medicine Meets The Challenge of A Changing World."

Two scientific sessions will be held, also in the Ballroom, featuring outstanding speakers.

A tour of the Marshall Space Flight Center and Redstone Arsenal has been arranged for Thursday afternoon, April 24. The tour will take about two and a half hours.

Registration

The registration desk for Counsellors, Delegates and members of the Association will be located in the Exhibition Area of the Carriage Inn Motor Hotel.

The desk will be open from 8:00 A. M., until 5:00 P. M., on Thursday and Friday, April 24 and 25, and from 7:30 A. M., until 10:30 A. M., on Saturday, April 26.

Counsellors and Delegates will be registered in advance and may claim their badges, a copy of the official program and any other material upon which they will be called to make decisions upon signing the official registration card.

Members and guests will be registered at the same place upon signing registration cards.

Exhibitors Registration

A registration desk for exhibitors will be located in the Exhibition area adjacent to the Carriage Inn Motel from 2:00 P. M., until 5:00 P. M., on Wednesday, April 23. Thereafter, exhibitors may register at the main registration desk.

Badges

No person will be admitted to any scientific, business, or social session of the Association, or to the exhibit area, unless he or she wears an official badge.

Speakers

Speakers will be called in the order in which they appear on the program. Should a speaker be absent when called, his paper will be passed and called again upon conclusion of the program.

Hotel Reservations

The Central Office of the Medical Association of the State of Alabama has established a Housing Bureau for the convenience of Counsellors, Delegates and members.

Advance registration requests have been distributed in the January, February and March issues of the Journal of the Medical Association of the State of Alabama.

The headquarters hotel will be the Carriage Inn Motor Hotel. Priority for the limited number of rooms available have been assigned to Counsellors, Delegates, officers of the Association and guest speakers. When the supply of rooms is exhausted, applicants will be referred to the Sheraton Motor Inn, Kings Inn Motor Hotel, Space Capitol Motel, Russell Erskine Hotel, Sand's Motor Hotel, and Ramada Inn.

Deadline for advance registration is April 10, 1969. After that date, reservations must be made directly with the hotel or motel.

Social Events

A full listing of social events of the 108th Annual Session will be published in the official program, available at the time of registration. Meetings of medical specialty groups will be scheduled either before or after the Annual Session inasmuch as the Constitution and Ordinances forbids this type of meeting during the three days allotted to the Annual Session. Social events for specialty groups and alumni organizations will be held on Thursday, April 24, 1969, at places and times to be announced.

Tickets for social events should be purchased in advance if possible. Otherwise, a limited number will be available at the registration desk.

Awards Dinner

The Awards Dinner will be held in the International Ballroom at the Carriage Inn Motor Hotel at 7 P. M., on Friday, April 25, 1969. The dinner will be sponsored by the Committee on Public Relations in honor of the winners of the 1969 awards, past presidents, and members of the Fifty Year Club. The following new members will be inducted into the Fifty Year Club:

B. Woodfin Cobbs, Montgomery.

William Grover Shamblin, Tuscaloosa.

Awards will be presented by C. A. Grote, Jr., M. D., Chairman of the Committee on Public Relations, to the following:

William Crawford Gorgas Award to the citizen of Alabama who is not actively engaged full time in the field of health and who has rendered outstanding service to Mr. Barrett Shelton, Sr., Editor-Publisher of the Decatur Daily News.

William H. Sanders Award to the person, lay or professional, engaged full time in public health work for services above and beyond the call of duty, to W. H. Y. Smith, M. D., Director of the Bureau of Preventable Diseases, State Health Department.

Douglas L. Cannon Medical Reporting Award to the reporter, editor or publisher, of an Alabama newspaper, or to a radio television personality who has shown excellence in factual reporting of medical news and for outstanding efforts in elevating medical news coverage, to Mr. Thomas W. (Wes) Diamond, Production Manager, WKRG, Mobile.

The A. H. Robins Company Award for the physician who has rendered outstanding service to his community above and beyond his professional call of duty to Aubrey E. Terry, M. D., of Russellville.

Board of Trustees

The Board of Trustees will meet at 9:00 A. M., on Wednesday, April 23, in Executive Room A at the Carriage Inn Motor Hotel, to sit as a reference committee in consideration of any and all matters of business to be presented at the 108th Annual Session. All Counsellors, Delegates and members of the Association are cordially invited to sit with the Board of Trustees and to present their views on matters under consideration.

Board of Censors

The Board of Censors will meet at 9:00 A. M., on Wednesday, April 23, in the Camellia Room of the Carriage Inn Motor Hotel to transact official business concerning the State Board of Medical Examiners and the State Committee on Public Health. Upon completion of discussions relating to the Board of Medical Examiners and the Committee on Public Health, the Board of Censors will convene to officially consider Association affairs, including matters referred by the Board of Trustees.

Other Events

Tuesday, April 22, 1969

Alabama Mental Health Board

The Alabama Mental Health Board will meet at 10:00 A. M., in Executive Rooms A and B, Carriage Inn Motor Hotel.

Wednesday, April 23, 1969

Alabama Orthopaedic Society

The Alabama Orthopaedic Society will hold a scientific and business session beginning at 10 A. M., followed by a reception-dinner at 6:00 P. M., in the Capital Room, Sheraton Motor Inn.

Alabama Chapter, American Academy of Pediatrics

The Alabama Chapter, American Academy of Pediatrics will hold a scientific session from 1:00 to 5:00 P. M., followed by a reception-dinner at 6:00 P. M., in the State Room, Sheraton Motor Inn.

Exhibitors Reception

The annual reception for representatives of exhibitors at the 108th Annual Session will be held from 4:00 P. M., to 5:00 P. M., in the Exhibition Area of the Carriage Inn Motor Hotel. Officers and members of the Board of Censors and Board of Trustees will be hosts at this reception.

Alabama Thoracic Society

The Alabama Thoracic Society will hold a Reception and Dinner at 6:00 P. M., in the International Ballroom, Carriage Inn Motor Hotel.

Alabama Academy of Ophthalmology and Otolaryngologists

The Alabama Academy of Ophthalmology and Otolaryngologists will hold a Reception and Dinner at 6:00 P. M., in Executive Rooms A and B, Carriage Inn Motor Hotel.

Alabama Society of Anesthesiologists

The Alabama Society of Anesthesiologists will hold a Reception and Dinner at 6:00 P. M., in the Camellia Room, Carriage Inn Motor Hotel.

Alabama Academy of Neurology and Psychiatry

The Alabama Chapter, American Academy of Neurology and Psychiatry will have a Reception and Dinner at 6:00 P. M., in the Empire Room of the Sheraton Motor Inn.

Thursday, April 24, 1969
Relaxation Hour

All members and their wives are invited to a Relaxation Hour following the Marshall Space Flight Center and Redstone Arsenal Tour.

Alumni Meetings

Vanderbilt Alumni Reception, 6:00 P. M., Executive Rooms A and B, Carriage Inn Motor Hotel.

Tulane Alumni Reception, 6:00 P. M., Camellia Room, Carriage Inn Motor Hotel.

University of Alabama Alumni Reception and Dinner, 6:00 P. M., Ballroom, Sheraton Motor Inn.

Las Vegas Party

The Las Vegas Party will begin at 8:00 P. M., in the International Ballroom of the Carriage Inn Motor Hotel. The Party will be

sponsored by the Madison County Medical Society.

Friday, April 25, 1969

ALAPAC Luncheon

The Fourth Annual ALAPAC Luncheon will be held at 12:30 P. M., in the International Ballroom of the Carriage Inn Motor Hotel.

Awards Dinner

The Awards Dinner will be held in the International Ballroom at 7:00 P. M., with Bart Starr, quarterback of the Green Bay Packers football team as guest speaker. To be honored at the Awards Dinner are Past Presidents of the Association; members of the Fifty Year Club; and winners of the William Crawford Gorgas Award, Douglas L. Cannon Medical Reporter Award, William Henry Sanders Award, and the A. H. Robins Community Service Award. The dinner will be presided over by Dr. C. A. Grote, Chairman of MASA's Committee on Public Relations.

Hosts of the Association

Official hosts of the Association will be the Madison County Medical Society, C. L. Butler, M. D., President. A Host Committee will be assigned to provide transportation and escort for visiting dignitaries.

PROGRAM

Opening Session

Thursday, April 24, 1969

Carriage Inn

International Ballroom



E. L. McCafferty, Jr., M. D., Mobile, President, Presiding

9:00 A. M.

Call to Order

Invocation



Dr. Tillman Sprouse, Minister, Trinity Methodist Church, Huntsville

9:05 A. M.

Welcome Address



Honorable Joe W. Davis, Mayor, Huntsville

9:10 A. M.

Welcome Address



President of Madison County Medical Society, Charles L. Butler, M. D.

Orientation

Carriage Inn

International Ballroom

THEME:

"MEDICINE MEETS THE CHALLENGE OF A CHANGING WORLD"



C. Kermit Pitt, M. D.. Decatur, President-Elect, Presiding

9:15 A. M.

Medical Organizations



John M. Chenault, M. D., Chairman, Board of Censors, and Member AMA Board of Trustees, Decatur

9:35 A. M.

Government Involvement In Medicine



Thomas H. Alphin, M. D., Director of Medical Services, State Department of Public Health, Montgomery

9:55-10:20 A. M.

COFFEE BREAK

10:20 A. M.

Law and Medicine in the Future



James N. Bloodworth, Associate Justice, Alabama Supreme Court, Montgomery

10:40 A. M.

The Physicians Handbook



L. P. Patterson, Executive Director, Medical Association of the State of Alabama, Montgomery.

11:10 A. M.

President's Message

E. L. McCafferty, Jr., M. D., Mobile

Thursday, April 24, 1969

Space Center Tour

B. B. Jordan, M. D., Tour Director

1:00 P. M. Buses depart Carriage Inn and Sheraton Motor Inn

1:20 P. M. Arrive Space Center and Army Missile Command
(Visitors will be divided into two groups for tours)



Welcome by Major General Charles W. Eifler, Commanding General, U. S. Army, Redstone Arsenal; and Mr. Bart Slattery, Jr., Chief of Public Affairs of NASA



2:00 P. M. Board buses for tour of Marshall Space Flight Center-NASA and U. S. Army Missile Command-Redstone Arsenal

4:30 P. M. Depart Space Center

5:00 P. M. Social Hour—Exhibit Area

6:00 P. M. University of Alabama Reception-Dinner—Grand Ballroom, Sheraton

Vanderbilt Alumni Reception—Executive Rooms A and B, Carriage Inn

Tulane Alumni Reception—Camellia Room, Carriage Inn

8:00 P. M. Las Vegas Party—International Ballroom, Carriage Inn—Sponsored by Madison County Medical Society.

Friday, April 25, 1969

First Scientific Session

Carriage Inn

International Ballroom

E. L. McCafferty, Jr., M. D., Mobile, President, Presiding

9:00-9:20 A. M.

A Welcome



Wernher von Braun, Ph. D., Director, NASA Marshall Space Flight Center, Huntsville

9:20-10:05 A. M.

View From The Moon



Frank Borman, Col., USAF, Commander world's first lunar spacecraft

Man's Response to Space Flight



Charles A. Berry, M. D., Director of Medical Research and Operations, NASA, Houston, Texas

10:05-10:50 A. M.

Panel Discussion

Physician-Engineer Interaction for Patient Care



Richard B. Shepard, M. D., Department of Surgery, University of Alabama Medical Center, Birmingham, Moderator

The Digital Computer as an Assistant to Physicians and Nurses—Experience in an Intensive Care Unit



Mr. Louis C. Sheppard, Department of Surgery, University of Alabama Medical Center, Birmingham

Physician-Engineer Interaction: Progress in Evaluation of Cardiac Disease



Harold T. Dodge, M. D., Department of Surgery, University of Alabama Medical Center, Birmingham



Cornelius Chung-Sheng Shih, Ph. D., Professor of Engineering Mechanics; Head, Fluidics Laboratory, University of Alabama in Huntsville



Spin-Off From Space

Mr. R. T. Schwinghamer, Special Assistant to the Director of Astronautics Laboratory



Mr. David J. Winslow, Aerospace Engineer, Huntsville



Robert E. Allen, Ph. D., Aerospace Scientist, Huntsville

10:50-11:00 A. M.
COFFEE BREAK

11:00 A. M.

Jerome Cochran Lecture

The Increasing Menace of Communism in the United States



Alton Ochsner, M. D., New Orleans, La., President, Alton Ochsner Medical Foundation

11:45 A. M.

Caucus of Counsellors and Delegates

Carriage Inn

Executive Rooms A and B

Friday, April 25, 1969

ALAPAC LUNCHEON

International Ballroom

12:15 P. M.



Grover C. Murchison, Jr., M. D., Montgomery, Chairman, ALAPAC, Presiding



Invocation

Rev. Barry Anderson, Minister, Latham Memorial Methodist Church, Huntsville

Introduction of ALAPAC Board of Directors



Address: James H. Sammons, M. D., Chairman, AMPAC Board of Directors, Highlands, Texas

Adjourn

Friday, April 25, 1969

Second Scientific Session

Carriage Inn



International Ballroom

S. Buford Word, M. D., Birmingham, Presiding

2:00-2:35 P. M.

The Management of Children With Febrile Diseases With A Rash



Joseph A. Little, M. D., Associate Professor of Pediatrics, Vanderbilt University, Nashville, Tenn.

2:35-3:10 P. M.

American Medicine Leads the Way



Dwight L. Wilbur, M. D., San Francisco, California, President of American Medical Association

3:10-3:45 P. M.

Cardiac Transplantation in Man: Late Results



Denton A. Cooley, M. D., Professor of Surgery, Baylor University College of Medicine, Houston, Texas

3:45-4:00 P. M.

COFFEE BREAK

4:00-4:30 P. M.

Progress in the Treatment of Patients with Chronic Renal Failure: The Changing Role of the Family Physician



H. Walker Brown, M. D., Associate Professor of Medicine, Director, Artificial Kidney Unit, University of Alabama Medical Center, Birmingham

4:30-5:10 P. M.

Sex and the Teen-Age Student



Richard K. Means, Ed. D., Professor of Health Education, Auburn University, Auburn

Friday, April 25, 1969

Awards Dinner

Carriage Inn
International Ballroom



Presiding

Carl A. Grote, Jr., M. D., Chairman, Committee on Public Relations, Huntsville



Invocation

Rev. Donald B. Bailey, Minister, First Presbyterian Church, Huntsville

Introduction of Distinguished Guests and Fraternal Delegates

E. L. McCafferty, Jr., M. D., President, Medical Association, State of Alabama



Awards Presentations

Ira B. Patton, M. D., Chairman, Subcommittee on Awards, Oneonta



William Crawford Gorgas Award

Mr. Barrett Shelton, Sr.



William Henry Sanders Award

W. H. Y. Smith, M. D.



Douglas L. Cannon News Reporter Award

Mr. Thomas W. (Wes) Diamond



A. H. Robins Community Service Award

Aubrey E. Terry, M. D.

Introduction of Past Presidents

Presentation of Fifty Year Club Members



B. Woodfin Cobbs, M. D., Montgomery



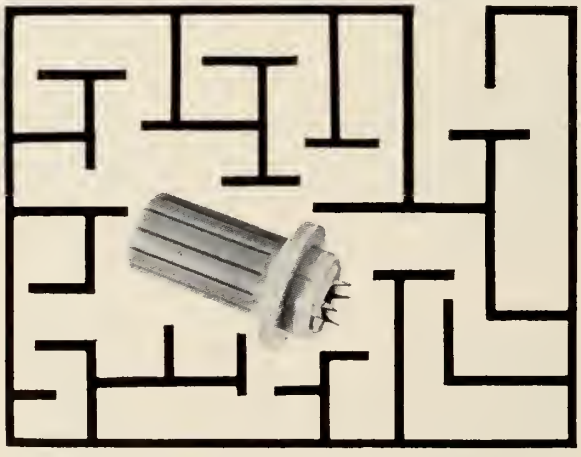
William Grover Shamblin, M. D., Tuscaloosa

Presentation of AMA-ERF Contribution



To Clifton K. Meador, M. D., Dean, Medical College of Alabama by Mrs. Richard A. Dillard, State AMA-ERF Chairman





HISTO IS CONFUSING.

Histoplasmosis can mimic such unrelated diseases as TB, leukemia, pneumonia and syphilis. Use the blue Histoplasmin LEDERTINE™ Applicator as the first step in differential diagnosis and as a routine step in physical examinations for the permanent records of your patients.

HISTOPLASMIN, TINE TEST

(Rosenthal)

Precautions—Nonspecific reactions are rare, but may occur. Vesiculation, ulceration or necrosis may occur at test site in highly sensitive persons. The test should be used with caution in patients known to be allergic to acacia, or to thimerosal (or other mercurial compounds).

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473-9



Introduction of Speaker

E. F. Porch, M. D., Chairman, Committee on the Medical Aspects of Sports, Arab



Address

Mr. Bart Starr, Quarterback, Green Bay Packers

Adjourn

(The Association gratefully acknowledges the financial contribution made by Blue Cross-Blue Shield of Alabama, Inc., toward the cost of this function.)

Saturday, April 26, 1969

Annual Business Session

Carriage Inn

International Ballroom

E. L. McCafferty, Jr., M. D.,
Mobile, President, Presiding

9:00 A. M.

Presentation by The Woman's Auxiliary to The Medical Association of The State of Alabama

Mrs. Robert K. Wilson, Sr.,
Aliceville, Immediate Past-President

(1) Report of The Board of Censors

(2) Revision of the Rolls
- (a) County Societies;
- (b) Counsellors;
- (c) Correspondents

(3) Election and Installation of Officers

(4) Presentation of Past President's Plaque

Adjournment



introducing alginates to antacids

for a difference in taste you can feel

Derived from seaweed, and long used to impart velvety consistency to foods, alginates—a Warner-Chilcott contribution to antacid palatability—help 1) erase the chalkiness and grittiness found with some other antacids; 2) dispel unpleasant aftertaste. Like ice cream, Gelusil-M is smooth and creamy; and it has a cool mint flavor. Thus, for your patients Gelusil-M may be better to start on and easier to stay on.

introducing new

GELUSIL®-M*

each 5 ml. teaspoonful contains:
500 mg. magnesium trisilicate
250 mg. aluminum hydroxide (Warner-Chilcott)
200 mg. magnesium hydroxide

*U.S. Patent No. 3,326,755

a consistent buffering anticostive† antacid

†Avoids constipation.

See next page for prescribing information ▶

GELUSIL—one name to remember...and a dosage form for every patient.



Gelusil®-M Liquid

especially for the constipation-prone patient

Indications: Gelusil-M is indicated for prompt and dependable symptomatic relief of peptic ulcer, gastritis, heartburn, hiatal hernia, esophagitis, and other conditions for which control of gastric hyperacidity is required.

Precaution: Prolonged or intensive therapy in patients with severe renal insufficiency may lead to hypermagnesemia.

Dosage: One to two teaspoonfuls (5 ml. to 10 ml.) between meals and at bedtime or whenever symptoms occur. Certain conditions, such as acute peptic ulcer, may require individualized dosage. If diarrhea occurs, reduce dosage or discontinue use.

Supplied: Gelusil-M (spearmint-flavored)—light green bottles of 12 fl. oz.; and a **special hospital pack.** Keep tightly closed—shake vigorously.

Gelusil® Tablets

the universal take-along antacid

Easy to take along / easy to take / pleasantly mint-flavored. An antacid with adsorbent and demulcent properties which contains in one tablet: 0.25 Gm. aluminum hydroxide (Warner-Chilcott) and 0.5 Gm. magnesium trisilicate (USP).

Dosage: 2 tablets—or more—between meals and at bedtime, or whenever symptoms occur. Tablets should be chewed.

Regular Gelusil® Liquid

when constipation is not a problem

Pleasant mint flavor...ideal for hospital or home. Available in 12 fl. oz. and 6 fl. oz. bottles and a special hospital pack. An antacid which contains adsorbent and demulcent agents in each 4 ml. teaspoonful: 0.25 Gm. aluminum hydroxide (Warner-Chilcott), 0.5 Gm. magnesium trisilicate (USP).

Dosage: 2 teaspoonfuls (4 ml. each)—or more—between meals and at bedtime, or whenever symptoms occur.

Also Available: Gelusil® Flavor-Pack, Gelusil-Lac®.

WARNER-CHILCOTT
Morris Plains, New Jersey
GM-IN-91-4C



around the state

New Physicians Licensed To Practice In Alabama



Paul James Batson, Jr., M. D., University of Tennessee College of Medicine, 1951, Reciprocity with Tennessee—Intends to locate in Gadsden.



Billy Marks Hightower, M. D., University of Tennessee College of Medicine, 1955, Reciprocity with Tennessee—Intends to locate in Mobile.

William Jerry Echols, M. D., West Virginia University School of Medicine, 1964. Reciprocity with National Board of Medical Examiners—Intends to locate in Selma (Craig AFB).



Francis Christian Huber, Jr., M. D., University of Tennessee College of Medicine, 1966, Reciprocity with Tennessee—Intends to locate in Birmingham.





James Humphrey Hickman, Jr., M. D., University of Pennsylvania School of Medicine, 1945. Reciprocity with Tennessee—Intends to locate in Birmingham.



Andrew Jackson Lanier, Jr., M. D., Louisiana State University School of Medicine, 1965, Reciprocity with Louisiana—Intends to locate in Pensacola (U. S. Naval Hospital).



John Clinton Norris, M. D., Creighton University School of Medicine, 1965, Reciprocity with Iowa—Intends to locate in Anniston (Ft. McClellan).



Jerrold Lawrence Terdiman, M. D., State University of New York Downstate Medical Center, 1964, Reciprocity with National Board of Medical Examiners, Intends to locate in Montgomery (Maxwell AFB).



George Robert Watts, M. D., Howard University College of Medicine, 1955, Reciprocity with Maryland—Intends to locate in Tuskegee.



David John Werner, M. D., University of Texas Southwestern Medical School, 1965, Reciprocity with Texas—Intends to locate in Montgomery (Maxwell AFB).



Dennis Harold Wetterholm, M. D., Stanford University School of Medicine, 1960, Reciprocity with California—Intends to locate at Fort Rucker.

Vital Statistics

NEW MEMBERS

Covington County

Williamson, Paul Shan, b 19, mc Univ. Okla. 46, recip Okla. 68, Route 8, Box 64, Andalusia, Ala. 36420. Research Medical Writer —222-4141.

Marengo County

Perrett, Norbert Earl, Jr., b 37, mc LSU 62, recip La. 68, 1100 South Cedar Ave., Demopolis, Ala. 36732—289-2190.

MEMBERS REMOVED

Conecuh County

Howell, Thomas Robert, 1726 Hamilton Terrace, Roanoke, Va. 24014—moved from state.

DEATHS

Dallas County

Doherty, Drayton Howard, P. O. Box 579, Selma, Ala. 36701—deceased January 12, 1969.

Montgomery County

Peterson, James Clay, 825 Adams Avenue, Montgomery, Ala. 36104—deceased January 8, 1969.

Wade, John Fletcher, Jr., 361 South Ripley Street, Montgomery, Ala. 36104—deceased January 13, 1969.

PICKENS COUNTY

Blakney, Emerson Ward, Reform, Ala. 35481 —deceased January, 1969.

CHANGE OF ADDRESS OF MEMBERS

Calhoun County

Bridges, Thomas E., present Alexandria, Ala. 36250, to 5 West 22nd Street, Anniston, Ala. 36201.

Covington County

Evers, Ray, present Andalusia, Ala. 36420, to P. O. Box 490, Andalusia, Ala. 36420.

Kyzar, J. H., present Andalusia, Ala. 36420, to P. O. Box 147, Andalusia, Ala. 36420.

McDonald, Juanita B., present Andalusia, Ala. 36420, to P. O. Box 730, Andalusia, Ala. 36420.

Parker, Leslie L., present Andalusia, Ala. 36420, to 205 South Three Notch Street, Andalusia, Ala. 36420.

Tomberlin, Charles G., present Andalusia, Ala. 36420, to P. O. Box 27, Andalusia, Ala. 36420.

Vickery, Robert E., present Andalusia, Ala. 36420, to P. O. Box 580, Andalusia, Ala. 36420.

Etowah County

Abernathy, Frank, Jr., present Gadsden, Ala. 35903, to 2030 Montreat Parkway, Birmingham, Ala. 35216.

Vance, Scott, present Gadsden, Ala. 35901, to P. O. Box 1668, Gadsden, Ala. 35902.

Fayette County

Garner, Mabry, E., present Fayette, Ala. 35555, to Fairfield Works Medical Center, Fairfield, Ala. 35064.

Henry County

Johnson, Joseph W., present Andalusia, Ala. 36420, to P. O. Box 758, Andalusia, Ala. 36420.

Jefferson County

Guffin, Gilbert T., present Gardendale, Ala. 35071, to 224 Ardella Circle, Birmingham, Ala. 35207.

Ippolito, Jerome G., present Birmingham, Ala. 35205, to 9228 Gadsden Highway, Birmingham, Ala. 35206.

Jumer, M. Mary, present Birmingham, Ala. 35233, to 1116 Ridge Lane, Wester Springs, Ill. 60558.

Lyons, James A., Jr., present Ft. Campbell, Kentucky 42223, to 6034 Ruskin Place, Indianapolis, Indiana 46224.

Maloof, John A., Jr., present Birmingham, Ala. 35233, to 7714 2nd Avenue South, Birmingham, Ala. 35206.

Ott, Willard R., present Birmingham, Ala. 35206, to 7832-2nd Avenue South, Birmingham, Ala. 35206.

Scofield, Paul D., present Cocoa, Fla., 32992, to 1040 Martha Lee, Rockledge, Fla. 32955.

Lauderdale County

Doss, Wilford C., Jr., present Florence, Ala. 35630, to 412 South Cedar Street, Florence, Ala. 35630.

Link, James D., present Florence, Ala. 35630, to 412 South Cedar Street, Florence, Ala. 35630.

Madison County

Rutledge, James W., present Huntsville, Ala. 35801, to 2515 South Parkway, Huntsville, Ala. 35801.

Montgomery County

Broadhead, Hal D., present Montgomery, Ala. 36107, to 3924 Wares Ferry Road, Montgomery, Ala. 36109.

Hutchinson, H. Hamilton, present Montgomery, Ala. 36104, to 339 South Ripley Street, Montgomery, Ala. 36104.

McBryde, Robert R., present Montgomery, Ala. 36104, to 339 South Ripley St., Montgomery, Ala. 36104.

Tisdale, William W., Jr., present Montgomery, Ala. 36104, to 339 South Ripley Street, Montgomery, Ala. 36104.

Williams, Thomas H., present Montgomery, Ala. 36106, to 2119 East South Boulevard, Montgomery, Ala. 36111.

Morgan County

Street, Herbert S., present Decatur, Ala. 35601, to Box 1423, Decatur, Ala. 35601.

Shelby County

Eddy, Corinne S., present Montevallo, Ala. 35115, to 358 Crestview Drive East, Montevallo, Ala. 35115.

MEMBERS TRANSFERRED

Montgomery County

Brantley, Joseph Kirven, Jr., 3018 Bryn Mawr Road, Montgomery, Ala. 36106. (Transfer from member of Lee County Medical Society to Montgomery County Medical Society.)

CORRECTION

Montgomery County

Change the name of Samuel Jefferson Underwood, 1031 Oak Street, Montgomery, Ala. 36108, to Solomon Jefferson Underwood.

NEW TELEPHONE NUMBERS

Hamilton, J. S.—355-7133

Hightower, D. P.—392-5332

Hunt, H. C.—652-5851

Long, J. R.—683-8269

Nelson, J. H.—759-1264

Norton, T. B.—392-4313

Parker, Mervel—288-5503

Walton, J. R.—392-5020

Webber, J. M.—298-7811

Williams, S. J.—652-5151

Dr. Sidney Mittler, Illinois biologist, who spent three years raising 100,000 fruit flies on a caffeine-enriched diet, has found that the offspring of these flies developed chromosome groupings of xo, xxy, xxx, and xyy; normal groupings are xy in the normal male, xx in the normal female. These odd groupings, according to an independent source quoted in the IBM magazine *Think*, produces sex deviates and criminals among human beings. Dr. Mittler said that he had given up drinking coffee and tea.

American College Of Physicians Plans 50th Session In Chicago

The semi-centennial session of the American College of Physicians is scheduled for Chicago April 20-25, with a spectacular array of features to appeal to every facet of medical practice.

There will be seven awards lectures, two of them bringing speakers from Edinburgh, Scotland, and Stockholm, Sweden. There will be a special educational exhibit on "Computers in Medicine." There will be 60 separate Meet-the-Professor Sessions, and 20 sessions of the Talks-with-the-Teacher series, each of the former limited to 20, the latter to 15 participants. A look into the future will be provided by a Colloquium on "The Future of Scientific Clinical Medicine—a Blueprint for Progress."

Regular features will include 30 scientific sessions for the presentation of original papers in the areas of: Cardiology, Endocrinology and Metabolism, Gastroenterology, Hematology, Infectious Diseases and Allergy, Kidney, Neoplasia and Neurology, Pulmonary Diseases, Psychiatry and Rheumatology.

And there will be panels on 16 subjects, among them "Mood and Mind Affecting Drugs," "Biological Events in Transplantation," "Controversial Issue in Treatment of Peptic Ulcer," "Cardiac and Pulmonary Hazards of Cigarette Smoking," "Drugs, Frugs, and Tugs," and twice that many more. Color television programs will cover a variety of subjects.

There is also a full five-day program for the ladies.

A post-convention tour of Mexico for the American College of Physicians is planned for April 26-May 3, with a three-way choice of Mexico City alone, Mexico City and Acapulco, and Mexico City and Yucatan.

See next page for prescribing information



You've made it one of your specifics in acute otitis media

DECLOMYCIN®
DEMETHYLCHLORTETRACYCLINE



You've made it one of your specific in acute otitis media

DECLOMYCIN acts against many strains of H. influenzae, pneumococci and streptococci, the most common invaders. In otitis media, where it is difficult to isolate the causative organism, this coverage may be important. However, some strain may be resistant and other pathogens can be involved.

You've found the high serum levels of DECLOMYCIN important, too. Its prolonged actio permits convenient 300 mg b.i.d. or 150 mg q.i.d. administration.

When specimens are obtainable, your culture studies will indicate the usefulness of DECLOMYCIN.

Effectiveness: DECLOMYCIN Demethylchlortetracycline should be equally or more effective therapeutically than other tetracyclines in infections caused by organisms sensitive to the tetracyclines.

Contraindication: History of hypersensitivity to demethylchlortetracycline.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocoli pruritus ani. Skin—maculopapular and erythematous rashes; a r case of exfoliative dermatitis has been reported. Photosensitiv onycholysis and discoloration of the nails (rare). Kidney—rise in Bl apparently dose-related. Transient increase in urinary output, sor times accompanied by thirst (rare). Hypersensitivity reactions—u caria, angioneurotic edema, anaphylaxis. Teeth—dental staining (low-brown) in children of mothers given this drug during the latter l of pregnancy, and in children given the drug during the neonatal p od, infancy and early childhood. Enamel hypoplasia has been see a few children. If adverse reaction or idiosyncrasy occurs, disconti medication and institute appropriate therapy. Demethylchlorte cycline may form a stable calcium complex in any bone-forming tis with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Sho be given 1 hour before or 2 hours after meals, since absorptio impaired by the concomitant administration of high calcium con drugs, foods and some dairy products. Treatment of streptoco infections should continue for 10 days, even though symptoms h subsided.

DECLOMYCIN®
DEMETHYLCHLORTETRACYCLINE

Capsules: 150 mg; **Tablets:** film coated, mg, 150 mg and 75 mg of demethylchlorte cycline HCl.

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Camera Glimpses of Most Successful of 17 Annual ACS Scientific Meetings

Left to right, top: Dr. Luther Hill, Montgomery, retiring president; Dr. Alton Ochsner, New Orleans, one of the headliners on the program; Dr. Walker Reynolds, Jr., Anniston, incoming president . . . Center: Dr. J. D. Peake, Mobile, standing; seated: Dr. Walker Reynolds, Jr., Dr. Ochsner, Dr. Sheridan Shirley, Birmingham, and Dr. John D. Thompson, Atlanta . . . Ladies in lower picture: Mrs. G. C. Buck, Jr., Birmingham; Mrs. Vernon Stabler, Greenville; Mrs. A. E. Thomas, Montgomery; Mrs. Walker Reynolds, Jr., Anniston.

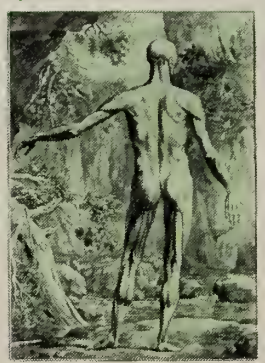


When familiar situations are a major challenge to your patient with low back pain



Norflex® meets the challenge

(orphenadrine citrate, 100 mg.)



Norflex relaxes the muscles in spasm, restoring mobility and hastening recovery.

Take the agony out of low back pain... prescribe Norflex, 1 tablet b. i. d.



To relieve skeletal muscle spasm... Norflex® tablets.
(orphenadrine citrate)

Indications:
Acute spasm of voluntary muscles, regardless of location; especially post-traumatic, discogenic, and tension spasms.

Contraindications:
Due to its anticholinergic action, NORFLEX should not be used in patients with glaucoma, pyloric or duodenal obstruction, stenosing peptic ulcer, prostatic hypertrophy or obstruction at the bladder neck, cardiospasm (megaesophagus) and myasthenia gravis. Use with caution in patients with tachycardia. Do not use propoxyphene (Darvon®) concurrently.

Adverse Reactions:
Due mainly to anticholinergic action and usually at high dosage. They may include dryness of the mouth, tachycardia, palpitation, urinary hesitancy or retention, blurred vision, dilatation of the pupil, increased ocular tension, weakness, nausea, vomiting, headache, dizziness, constipation and drowsiness. Infrequently, mental confusion in the elderly, urticaria or other dermatoses. Adverse reactions are usually eliminated by reduction in dosage. Two cases of aplastic anemia, with no established causal relationship, have been reported.

Dosage and Administration:
Two tablets per day for adults, regardless of weight or sex; one in the morning and one in the evening. Each tablet contains 100 mg. orphenadrine citrate.

For full information, see Package Insert or P.D.R.

Norflex®
(orphenadrine citrate)

Riker Laboratories
Northridge, California 91324



The Month in Washington

From the Washington Office
American Medical Association

Washington, D. C.—The American Medical Association told Congress that the Internal Revenue Service acted arbitrarily and completely ignored the facts in imposing a tax on revenue from drug advertising in journals of tax-exempt medical associations.

Bernard D. Hirsh, AMA general counsel, testified before the House Ways and Means Committee, that the relation between the tax-exempt purposes of a medical association, national or state, and the drug advertising in its journal is self-evident.

"Drug advertising alerts and stimulates the physician's interest in new drugs as they become available, and also serves to remind him of the broad spectrum of useful time-proven drugs," Hirsh said. "Obviously physicians should not and do not rely upon drug advertisements as their principal source of information, but drug advertisements often provide an important step in the process through which physicians become educated in the therapeutic value and risks of new drugs and a wider variety of useful drugs....

"No other advertising provides as much complete and objective information."

Hirsh said the IRS regulations taxing medical associations on their advertising revenues represents an attempt to change the law without congressional action. The IRS officials made a mistake, he said.

"We urge that this mistake be rectified expeditiously and in the most practical way possible," Hirsh said.

Spokesmen for numerous other tax-exempt

associations joined the AMA in opposing the tax on their advertising revenues. These included the American College of Physicians, the American College of Obstetricians and Gynecologists, the American Psychiatric Association, the American Dental Association, the Boy Scouts of America, the Girl Scouts of America, the American Chemical Society and the Society of National Association Publications.

Representatives of commercial publishing firms contended in testimony before the committee that the previous tax exemption gave the journals of the associations an unfair advantage in competition for advertising dollars. When the IRS announced the new tax regulations 15 months ago, it stated that the purpose of the regulations was not to raise federal revenue but to remove a competitive advantage of the tax-exempt associations.

In an announcement not directly connected with the House committee hearings, the IRS said it also is considering taxing the income tax-exempt associations get from rental of exhibit and display space at conventions.

* * *

A special advisory committee urged an extensive national program to combat alcoholism.

The National Advisory Committee on Alcoholism said in an interim report that attention should be given to alcoholism problems in all federally supported health and welfare programs. The committee also recommended:

Elimination by hospitals of discriminatory policies denying admission to alcoholic patients; health insurance coverage for alcoholics; increased support for research; prevention and control of alcoholism as a vital part of national highway safety programs.

* * *

The National Institute of Mental Health awarded a first-year grant of $250,000 for a major alcoholism research program at the State University of New York, Downstate Medical Center, New York, N. Y.

The five-year program will include experimental and clinical studies, training, and drug trials. In one study, 60 newly admitted patients between the ages of 25 and 55 with at least a five-year history of alcoholism will be studied to determine the effects of experimentally induced intoxication and withdrawal on the subjects' sleep patterns, behavior and biochemistry. The investigators will focus upon the mechanisms underlying the development of physical and psychological dependence.

Among the drugs to be tested are haloperidol, dexoxadrol, disulfiram (antabuse), paraldehyde and chlordiazepoxide alone and in combination with a tranquilizer and an antidepressant.

* * *

The federal government is planning to launch a five-year, nationwide program of inoculation against rubella, or German measles, as soon as a vaccine is licensed and available in sufficient quantities. It is expected a vaccine will be available by next fall.

Two drug manufacturers had announced before March 1 the development of a vaccine. Two others were developing one. Merck & Co., Rahway, N. J., was the first to announce completion of testing of such a vaccine. The Merck vaccine, which is of the HPV-77 strain, was reported 95 per cent effective in vaccination of 18,000 children and adults. Merck also has been testing a one-shot vaccine against German measles, common measles and mumps.

PEPI Inc., New York, N. Y., said that it had developed a modified live virus vaccine, also of the HPV-77 strain, for the disease and that, after being licensed, it would be marketed by Philips Roxane Laboratories and Parke Davis & Co. PEPI said initial production would be primarily a single-dose vaccine for use in pediatric practice, but that later production would include dosage forms suitable for government-sponsored mass-vaccination programs.

(Continued on Page 948)



Photo professionally posed.

No injection after all!

This penicillin produces high, fast levels—orally.

Pen•Vee® K is usually so rapidly and completely absorbed that therapeutic penicillin levels are attained within 15 to 30 minutes. Thus it can often obviate the need for penicillin injections. The higher serum levels produced generally last longer than with those of oral penicillin G.

Indications: Infections susceptible to oral penicillin G; prophylaxis and treatment of streptococcal infections; treatment of pneumococcal, gonococcal, and susceptible staphylococcal infections; prophylaxis of rheumatic fever in patients with a previous history of the disease.
Contraindications: Infections caused by nonsusceptible organisms; history of penicillin sensitivity.
Warnings: Acute anaphylaxis (may prove fatal unless promptly controlled) is rare but more frequent in patients with previous penicillin sensitivity, bronchial asthma or other allergies. Resuscitative (epinephrine, aminophylline, pressor amines) and supportive (antihistamines, methylprednisolone sodium succinate) drugs should be readily available. Other rare hypersensitivity reactions include nephropathy, hemolytic anemia, leucopenia and thrombocytopenia. In suspected hypersensitivity, evaluation of renal and hematopoietic systems is recommended.
Precautions: In suspected staphylococcal infections, perform proper laboratory studies including sensitivity tests. If overgrowth of nonsusceptible organisms occurs (constant observation is essential), discontinue penicillin and take appropriate measures. Whenever allergic reactions occur, withdraw penicillin unless condition being treated is considered life threatening and amenable only to penicillin. Penicillin may delay or prevent appearance of primary syphilitic lesions. Gonorrhea patients suspected of concurrent syphilis should be tested serologically for at least 3 months. When lesions of primary syphilis are suspected, dark-field examination should precede use of penicillin. Treat beta-hemolytic streptococcal infections with full therapeutic dosage for at least 10 days to prevent rheumatic fever or glomerulonephritis. In staphylococcal infections, perform surgery as indicated.
Adverse Reactions: (Penicillin has significant index of sensitization) Skin rashes, ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; serum sickness-like reactions, including chills, fever, edema, arthralgia and prostration. Severe and often fatal anaphylaxis has been reported (see "Warnings").
Composition: Tablets—125 mg. (200,000 units), 250 mg. (400,000 units), 500 mg. (800,000 units); Liquid—125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc.

Wyeth Laboratories Philadelphia, Pa.

ORAL PEN•VEE® K

(potassium phenoxymethyl penicillin) Wyeth

(Continued from Page 946)

The other two companies developing a rubella vaccine are Smith, Kline & French laboratories, Philadelphia, and Eli Lilly & Co., Indianapolis. Eli Lilly has been developing a HPV-77 strain. Smith, Kline & French was working on a Cendehill strain. It had proved 95 per cent effective in inoculations of more than 25,000 persons, according to the manufacturer. Another vaccine, using a rubella strain RZ 27-3, has been developed at the University of Pennsylvania.

* * *

Rep. Ancher Nelsen (R., Minn.) has introduced legislation calling for the same federal tax treatment for professional corporations of physicians organized under state law as for business corporations.

"We are overdue in acting to guarantee this same right of organization to professional persons that we have always given other forms and types of businesses," Nelsen told the House.

He noted that the federal government's so-called Kintner regulations issued in 1960 primarily keyed taxation of professional corporations to state law.

"As a result," he said, "many states, Minnesota included, passed laws enabling incorporation under these regulations. Assuming the air was cleared, many corporations were formed. However, in 1965, the Internal Revenue Service issued new regulations reversing its position, which if upheld, make it almost impossible to create a professional corporation, regardless and in spite of state laws permitting the same.

"No business can operate without some basis of continuity of the ground rules. If any set of rules should be stable, the rules governing the basic tax classification of businesses for tax purposes should be stable and not subject to administrative whim. Businesses, almost without exception—except for the professions with which this bill deals—are now allowed to decide whether to adopt the partnership, association or corporate form under applicable state laws. There is no logical reason for denying this choice to persons who are rendering personal services in the medical or legal fields. Fairness and equity in application of the federal income tax laws demands that all businesses be treated alike in this sense.

"The only apparent reason for the 1965 amendments to the regulations was to prevent a possible reduction in federal revenues. I am certainly convinced that this is not an adequate reason for ignoring years of legal precedent and congressional intent in this field. Furthermore, the providing of health, pension and profit-sharing plans through tax incentives under the corporate structure is a worthy objective and a legitimate use of the tax laws. Indeed, I am advised that any possible total tax revenue loss will be minimal when it is realized that most profits will be ultimately taxable, even though such taxation might be immediately deferred.

"The position taken by the Internal Revenue Service in 1965 is untenable. It violates fairness, equity, reasonableness, years of legal precedent, and the intent of Congress as to the tax treatment of business organizations operating legitimately under state law. I would urge all my colleagues to support hearings and passage of this needed legislation at the earliest possible date."

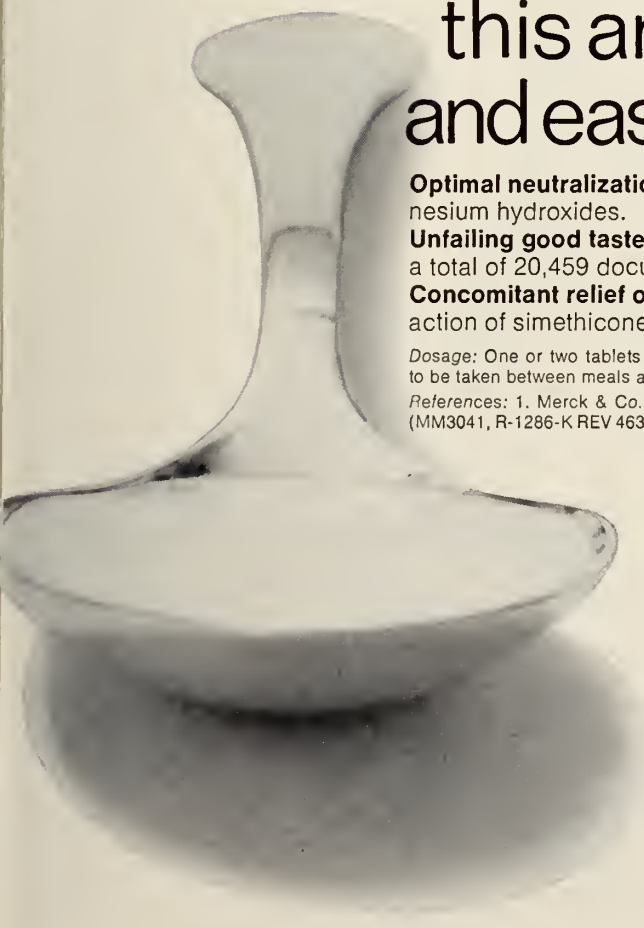
* * *

Sen. Clinton Anderson (D., N. M.) introduced a bill to tie medicare and medicaid payments to hospitals and nursing homes to local Blue Cross allowances. The bill complements a measure introduced by Sen. George D. Aiken, (R., Vt.) earlier this year which ties physicians' charges to Blue Shield schedules.

Anderson also said he supports the idea of Sen. John J. Williams (R., Del.) that Congress should give medicare and medicaid programs a close look, perhaps a full-dress investigation.

the thousandth teaspoonful

Peptic ulcer patients find the thousandth dose of this antacid as effective and easy-to-take as the first!



Optimal neutralization[1] — provided by the combination of aluminum and magnesium hydroxides.

Unfailing good taste — confirmed by 87.5% of 104 patients in one study, after a total of 20,459 documented days on Mylanta Liquid or tablets.[2]

Concomitant relief of G. I. gas distress — provided by the proven antiflatulent action of simethicone[3].

Dosage: One or two tablets (well chewed or allowed to dissolve in the mouth); one or two teaspoonsful to be taken between meals and at bedtime, or as directed by physician.

References: 1. Merck & Co., Merck Chemical Division: Antacid Literature Survey, Rahway, New Jersey. (MM3041, R-1286-K REV 463.) 2. Danhof, I.E., report on file. 3. Hoon, J.R.: Arch. Surg. *93*:467 (Sept.) 1966.

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LIQUID/TABLETS
aluminum and magnesium hydroxides *plus* simethicone

Stuart Division/ATLAS CHEMICAL INDUSTRIES, INC./Pasadena, Calif. 91109



A Plan For Physician Education And Communication

By Margaret S. Klapper, M. D.

Director

Division of Continuing Medical Education

Medical College of Alabama

Today's practicing physician is burdened by a steadily increasing patient load and a mounting wave of medical advances that have led to rapidly changing concepts in the diagnosis, management, and treatment of patients. As a result, the practitioner is often faced with medical and/or surgical problems that fall into the province of the well-trained subspecialist. To answer questions that arise concerning his patients, or to solve their problems, the practicing physician must spend considerable time during or toward the end of the day searching medical journals or texts that are often inadequate for his needs. This is a time-consuming process for the physician and a potentially dangerous one for the acutely ill patient. The only alternative available to the practitioner is to seek the aid of a medical or surgical consultant, but this is not practical or possible for all practicing physicians. In the urban area consultants may be readily available, but in small communities the practitioner is usually alone and often has no one readily available for consultation. Hence, his only recourse is either to solve his own medical problems or to call upon the services of a nearby medical center. As a result of such needs, the University of Alabama Medical Center receives approximately 200 telephone calls monthly requesting information and assistance pertaining to diagnosis, treatment, etc.

Once the physician who is seeking medical advice or counsel reaches the Medical Center, his problem is still not automatically solved. Often he is unfamiliar with the facilities of the Medical Center; he is unaware of the subspecialties available to him; or he is uncertain as to the appropriate medical or surgical group to contact. Occasionally, the telephone operator at the Medical Center can help the physician in placing his call proper-

(Continued on Page 953)

"anorectal disorders"



This Rectopath Model
may help you explain
certain anorectal disorders
to some of your patients.
It is yours on request.

See next page for details.

"anorectal disorder"

includes a range of problems
For symptomatic relief in some of these disorders consider a member of the Anusol Family...

One suppository morning and evening and after each bowel movement.

ANUSOL®

soothing, palliative relief of minor pain, itching, burning, and other associated discomforts.

Each ANUSOL suppository contains bismuth subgallate (2.25%), bismuth resorcin compound (1.75%), benzyl benzoate (1.2%), Peruvian balsam (1.8%), zinc oxide (11.0%), and boric acid (5.0%), plus the following inactive ingredients: bismuth subiodide, calcium phosphate, hydrogenated vegetable oil, and coloring in a cacao butter and white wax base.

One suppository morning and evening for 3 to 5 days.

ANUSOL-HC®

prompt reduction of inflammation plus the soothing effects of regular Anusol.

Each ANUSOL-HC suppository contains, in addition to the regular Anusol formula, 10 mg. hydrocortisone acetate.

Precautions: Prolonged use of Anusol-HC might produce systemic corticosteroid effects.

One suppository every 3 to 4 hours, or every 2 hours if symptoms are severe.

ANUGESIC®

when severe pain requires prompt relief, pramoxine HCl plus the soothing Anusol formula.

Each ANUGESIC suppository contains: 61 mg. bismuth subgallate, 47 mg. bismuth resorcin compound, 32.4 mg. benzyl benzoate, 48.6 mg. Peruvian balsam, 300 mg. zinc oxide, 135 mg. boric acid, and 25 mg. pramoxine hydrochloride. Also contains the following inactive ingredients: bismuth subiodide, calcium phosphate, white wax, benzoinated lard, hydrogenated vegetable oil, and certified coloring in a cacao butter base.

Precautions: If idiosyncratic reaction occurs, discontinue medication.
Symptomatic treatment should not be allowed to delay definitive diagnosis and therapy.

Also available: ANUSOL® OINTMENT AND ANUGESIC® OINTMENT



The Rectopath Model is available from your Warner-Chilcott representative or upon request from Warner-Chilcott Labs., Morris Plains, New Jersey 07950.

WC Warner-Chilcott Laboratories, Morris Plains, N. J.

AN-IN-91-4C

(Continued from Page 950)

ly, but all too often she is not familiar with the proper groups to contact, and as a result there is delay, confusion, a relaying of telephone calls, a fraying of tempers, or complete frustration. If this happens, the physician may hesitate to call in the future. Such an event is not conducive to good medical relationships, to good patient care, nor to continuing medical education.

For these reasons, several measures have been proposed to assist the practitioner of medicine in solving his medical problems and in handling his medical referrals and/or consultations. These proposals can be and should be linked to continuing medical education. To implement them, a subcommittee has been formed under the jurisdiction of the Division of Continuing Medical Education. It is charged with the responsibility for developing and using available means of audio-visual communications to help the practitioner. Three proposals are currently under consideration by this committee. These are (1) a Statewide Telephone Information Service, (2) a Physician Exchange Program, and (3) a Medical Audiovisual Program. The first proposal, that is, the Statewide Telephone Information Service, can be implemented in the near future, and it has the endorsement of the Physicians Advisory Board to the Medical College of Alabama, the Committee on Medical Education and Hospitals, and the Board of Censors of the Medical Association of the State of Alabama.

1. Statewide Telephone Information Service (TIS)

This service is designed to bring immediate medical information to physicians practicing in all parts of the state. To implement the TIS, it will be necessary to have an outgoing and incoming WATS line (approximate cost $1,000 per month) and a Medical Center Referral Unit. The program will be initiated with the faculty of the Department of Medicine. Later, it is anticipated that other departments such as Surgery, Pediatrics, etc. will be incorporated into the TIS, as will services in drug information, dietetics, and the like.

The TIS will be organized internally so that all telephone calls for medical assistance coming into the Center will be monitored day and night and referral made to appropriate medical subspecialties. Initially, it is planned to have six recognizable subspecialty groups participate in the TIS. These will include the following:

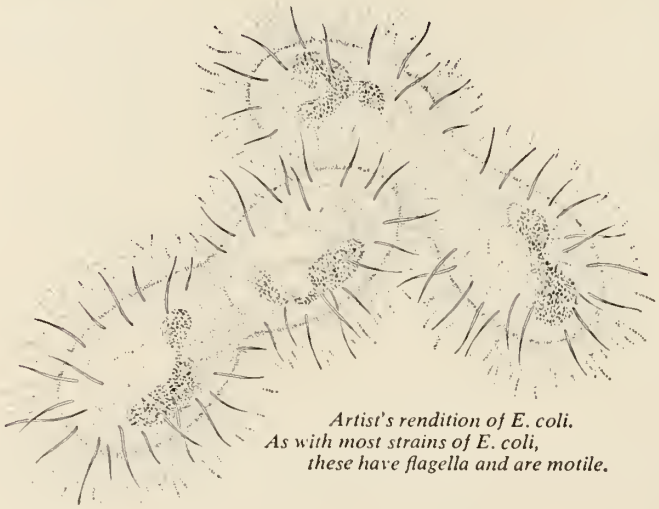
1. **Cardiology**
2. **Gastroenterology—Hematology**
3. **Endocrinology & Diabetes**
4. **Renal**
5. **Pulmonary**
6. **Infectious Diseases**

In addition, groups will be available to handle telephone calls concerned with problems in General Medicine, Dietetics, and Toxicology or Poisons. Each subspecialty group will consist of a designated group of specialists who will rotate by roster so that they will be available to answer questions pertaining to their subspecialties through the day. Incoming telephone calls will be monitored by a recorder and the appropriate group contacted (by "beeper") immediately by a special switchboard operator, who will have at her disposal a daily roster of physicians on call. This will place the practitioner into almost immediate contact with the desired specialist within the Medical Center. It is anticipated that the resulting consultations will be recorded by the Referral Unit. This will permit maintenance of a record indicating the nature of the call, the referring physician, his area within the state, the subspecialty, the consultant, and the nature and solution of the medical and/or surgical problem. This record will then be available for future analysis.

Telephone calls made to the Referral Unit during the night would be recorded within

(Continued on Page 956)

To help avert chronicity in acute cystitis



Artist's rendition of E. coli. As with most strains of E. coli, these have flagella and are motile.

Although it may coexist with chronic pyelonephritis or prostatitis, many cases of chronic cystitis may result from incomplete treatment of a simple, acute cystitis. For this reason, it is being increasingly recommended that appropriate antibacterial therapy in full dosage be maintained for up to two weeks or longer.

Most frequently, the dominant pathogen is gram-negative, usually *E. coli;* most often, you will find Gantanol® (sulfamethoxazole) effective against *E. coli* and other sensitive organisms—gram-positive and gram-negative—commonly seen in cystitis and other urinary tract infections. Wide clinical usage of Gantanol has confirmed the efficacy of this wide-spectrum antimicrobial agent in the treatment of cystitis.

The rapidity of bacterial multiplication in a favorable urinary environment is well known. Prompt control of acute bladder infection is therefore essential

---

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Acute and chronic urinary tract, respiratory and soft tissue infections due to susceptible microorganisms; prophylactically following diagnostic instrumental procedures on genitourinary tract.

Contraindicated in sulfonamide-sensitive patients, pregnant females at term, premature infants, or newborn infants during first 3 months of life.

Warnings: Use only after critical appraisal in patients with liver or renal damage, urinary obstruction or blood dyscrasias. Deaths reported from hypersensitivity reactions, Stevens-Johnson syndrome, agranulocytosis, aplastic anemia and other blood dyscrasias. In closely intermittent or prolonged therapy, blood counts and liver and kidney function tests should be performed. Clinical data insufficient on prolonged or recurrent therapy in chronic renal diseases of children under 6 years.

Precautions: Occasional failures may occur due to resistant microorganisms. Not effective in virus and rickettsial infections. Sulfonamides not recommended

not only to reduce the patient's discomfort but to prevent chronicity and possible ascending infection.

Gantanol (sulfamethoxazole) provides antibacterial activity within two hours of the initial 2-Gm dose, and subsequent 1-Gm doses, taken morning and evening, maintain therapeutic blood and urine levels lasting up to 12 hours. Significant symptomatic response is frequently achieved within 24 to 48 hours in acute, uncomplicated cystitis and other responsive urinary tract infections. In addition, Gantanol is usually well tolerated. Should prolonged therapy be required, the convenient *b.i.d.* dosage helps to minimize the problem of skipped doses.

Over eight years' clinical use has thoroughly demonstrated the qualities that make Gantanol a good choice for initial therapy of most urinary tract infections, including acute cystitis.

---

for therapy of acute infections caused by group A beta-hemolytic streptococci. At present, penicillin is drug of choice in acute group A beta-hemolytic streptococcal infections; although Gantanol has produced favorable bacteriologic conversion rates in this infection, data insufficient on long-term follow-up studies as to its effect on sequelae of rheumatic fever or acute glomerulonephritis. If other treatment cannot be used and Gantanol is employed in such infections, *important that therapy be continued in usual recommended dosage for at least 10 days.* Observe usual sulfonamide therapy precautions, including adequate fluid intake. Use with caution if history of allergies and/or asthma. Follow closely patients with renal impairment since this may cause excessive drug accumulation. Need for indicated local measures or surgery not obviated in localized infections.

Adverse Reactions: Depending upon the severity of the reaction, may withdraw drug in event of headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, Stevens-Johnson syndrome, skin rash, injection of the conjunctiva and sclera, petechiae, purpura, hematuria and crystalluria.

Gantanol® (sulfamethoxazole) assures rapid, sustained, antibacterial activity with b.i.d. dosage

Gantanol® B.I.D. (sulfamethoxazole)

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Nutley, New Jersey 07110

(Continued from Page 953)

the unit. The following morning these calls would be referred to the appropriate specialist, who will be charged with contacting the practitioner and assisting him.

Plans also include sending pertinent reference material (reprint or copy) from the medical literature to the practitioner so that he can familiarize himself with the latest methods of diagnosis and treatment. This is medical information relative to an immediate need of the physician and to a need that has recently been encountered. It is hoped that the physician will use this reference to familiarize himself with the latest trends in therapy or in diagnosis as applicable to his patient. This approach will also serve to continue the physician's medical education.

The service (TIS) will be available to all communities in the state through the statewide WATS line. However, a rural, urban, and two intermediate sized communities will be selected for detailed study and evaluation. In these selected communities the TIS will be emphasized by direct and individual contact with local physicians, by contact with local health departments, through hospital displays within the communities, and perhaps by local publicity via news media. Information and results so obtained will serve to direct the course taken in other communities to familiarize physicians with the use of TIS, as a guide toward broadening the scope of TIS and in undertaking the next steps of the plan for physician education and information.

It is hoped that adequate funding can be achieved by funds derived from granting agencies such as Comprehensive Health Planning, Appalachia Regional Program, Regional Medical Program, Bureau of Health Manpower, etc. A project proposal for an operational grant to ARMP will be made in the near future as the first step toward financial support.

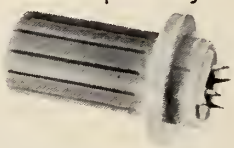
2. Physician Exchange Program (PEP)

The aim of the Physician Exchange Program will be to return a physician to the University Medical Center for a brief and concentrated refresher course in an area of his medical interest. This is a form of continuing medical education that may have an attraction for many practitioners. To cover the absence of the practitioner during this period, it is anticipated that a senior resident or junior faculty member would be made available by the Medical Center to substitute for the physician in his home community. This would enable the practitioner to learn newer techniques and methods and to advance his skills without depriving the community of the services of a physician. At the same time it would permit young physicians to become familiar with the problems of the community physician and community medicine.

It is hoped that this program also would

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is still
around.

In 1967 almost 45,000 new active cases were reported. Isn't that a good reason to make tuberculin testing with the white LEDERTINE™ Applicator a routine part of your physical examinations?



TUBERCULIN
TINE TEST
(Rosenthal) with Old Tuberculin

Precautions: With a positive reaction, consider further diagnostic procedures. Use with caution in persons with active tuberculosis or known allergy to acacia. Vesiculation, ulceration, or necrosis may occur at the test site in highly sensitive persons.

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472-9

lead to better understanding and cooperation between the University Medical Center and physicians throughout the state.

3. Medical Audiovisual Program (AVP)

This part of the Continuing Medical Education Program will be stressed from two aspects, namely, physician education and patient education.

(A) Physician Education. A study will be made of the needs of the practicing physician in urban and rural Alabama. His needs may differ strikingly from those of the physician practicing medicine in the Eastern, Western, or Central United States. After analysis of the needs of the Alabama physician, a series of audiovisual packets will be designed to help fulfill these needs and to provide teaching aids for local communities. Initially, teaching aids will be prepared for the following categories: (1) life threatening emergencies and their management; (2) common errors in diagnosis and treatment; (3) pertinent reviews concerned with new therapeutic agents and diagnostic techniques. Recurring questions and problems identified through the TIS will help to identify other categories.

The Division of Learning Resources will be asked to participate in these services and to provide technical assistance and guidance in the creation of film strips, teaching slide sets, video tape films, etc. Training aids available from Federal sources also will be reviewed, and when appropriate these will be incorporated into the program.

(B) Patient Education. This program will be directed toward teaching patients how to administer drugs (e.g. the diabetic), how to avoid complications related to their diseases (e.g. good foot hygiene for the patient with arteriosclerosis or diabetes), home aids for management of the patient with a stroke, cancer of long standing, etc. The feasibility and the practicability of exploring areas designed to educate the chronically ill patient also will be evaluated.

The proposed plan for physician education and information is an ambitious one. It is being met with enthusiasm by members of the faculty of the Medical College of Alabama. It has the advantage of incorporating educational aspects into the delivery of health care at the time and place where it is needed. When it is fully implemented, it will be an integral part of the continuum of medical education involving student, housestaff, faculty, practicing physician, and other health personnel in effecting the goal of better health care in Alabama.

Margaret S. Klapper, M. D.,

Director, Division of
Continuing Medical Education

DRUG DEPENDENCE

Drug Dependence: A Guide For Physicians (as well as other professionals working in the complex field of drug abuse and dependence) is a new 186-page paperback book containing much information already published previously, and separately, either in *The Journal of the American Medical Association* or *The Archives of General Psychiatry.* AMA's Order Handling Department, 535 North Dearborn Street, Chicago, Ill. 60610 is the book's distributor, and the price is $1.

Former Secretary of State Dean Rusk, formerly president and now a Distinguished Fellow of the Rockefeller Foundation, is one of the speakers for the American Medical Association's fourth conference on International Health, scheduled May 22-23 at the LaSalle Hotel, Chicago. The general theme of the conference is "U. S. Efforts in International Health Today and Tomorrow."

PHYSICIAN PLACEMENT SERVICE IN ALABAMA

The Physician Placement Service of the Medical Association of the State of Alabama is designed to assist both physicians and communities. MASA members having knowledge of practice opportunities or wishing to relocate their own practices are urged to communicate with the Placement Service. For further information: write Mr. Emmett Wyatt, Executive Assistant, Medical Association of the State of Alabama, 19 South Jackson Street, Montgomery, Alabama 36104, or Telephone 263-6441.

Locations Wanted

General Practice—

Age 44, Medical College of Alabama, 1967, seeking associate practice in town of 12,000 plus population in central or south Alabama. LW-1

Age 56, Georgetown University 1938; seeking solo, group or associate practice, with general surgery. LW-2

Age 52; University of Chicago 1950; seeking group, industrial, institutional or student health position. LW-3

Age 31, Western Reserve, 1964; seeking group, associate or institutional practice. LW-4

Age 38; University of Oklahoma, 1955; seeking associate, institutional or industrial practice; in town of 10,000 plus population; interest in surgery. LW-5

Age 28; Medical College of Alabama 1966; seeking practice in town of less than 14,000 population to fulfill scholarship requirements. LW-6

Age 28; University of Tennessee, 1965. LW-7

Age 27, Medical College of South Carolina, 1966; seeking location in Gadsden area or in southern part of state in town of 5-7,000 population; available July 1, 1971. LW-7/1

Age 38; Medical College of Alabama, 1957; seeking location in south Alabama. LW-7/2

Age 60, University of Arkansas 1932, seeking location for general or industrial practice. Available May 1969. LW-7/3

Internal Medicine—

Age 36, Medical College of Alabama, 1963; seeking solo, group, or associate practice. LW-8

Age 34; Hahnemann Medical College 1959; Board eligible, National Board; seeking solo, group, or associate practice. Available immediately. LW-11

Age 35; University of Tennessee 1958; Board certified; seeking group, industrial or institutional practice. LW-12

Age 37, Duke University, 1956; Board certified, seeking group, associate, or institutional practice. LW-13

Neurology—

Age 32, Medical College of Georgia, 1964, seeking assistant or associate, or institutional practice. LW-14

Age 31; Harvard 1962; Board eligible; National Board; seeking solo, group or associate practice. Available July 1969. LW-15

Age 30; Medical College of Alabama 1962; Board eligible; National Board; seeking solo, group, associate or institutional practice. Available January 1969. LW-16

Age 29, Indiana Univ., 1964; Board eligible; seeking assistant or associate practice in city of over 100,000 population; available July 1, 1969. LW-17/1

Obstetrics-Gynecology—

Age 35, Vanderbilt University, 1950. Board eligible. LW-18

Age 49, University of Nebraska, 1943; Board certified, seeking group or institutional practice. LW-19

Age 34, Medical College of Virginia, 1961, Board eligible, seeking group or associate practice. LW-20

Age 33; University of Illinois, 1964; seeking associate practice. LW-21

Ophthalmology—

Age 33; St. Louis University, 1962; seeking solo, or associate practice; available July 1, 1969. LW-21/1

Otolaryngology—

Age 32, University of Pennsylvania 1962, seeking associate practice. Available April 1970. LW-21/2

Psychiatry—

Age 52, Chicago Medical School 1939; Board eligible; seeking group or institutional practice, preferably near Gulf Coast. LW-22

Surgery—

Age 30; Duke University School of Medicine, 1964; seeking location in larger cities. LW-26

Age 33; University of Missouri, 1961; seeking group or associate practice. Available January 1969. LW-27

Age 38; Emory University, 1956; Board eligible, seeking group, associate, or institutional practice. LW-28

Age 37; Faculty of Medicine, Manitoba, 1957; Board certified; seeking associate or institutional practice. LW-29

Age 34; University of Santo Tomas, 1961; Board eligible, seeking group or associate practice. LW-30

Age 35; University of Santo Tomas, 1956; Board eligible, seeking solo, group or industrial or associate or institutional practice. LW-31

Age 36, Indiana University 1961; Board eligible; seeking practice in city of 100,000 plus population. Available July 1969. LW-31/1

Locations Wanted
(Continued)

Age 37, University of Paris 1961; seeking group or institutional practice in city of 80,000 plus population. Available July 1969. LW-31/2

Urology—

Age 30; Louisiana State University, 1963; Board eligible, seeking associate, or group practice. LW-32

Physicians Wanted

Special Openings—

Specialist in the following fields: Internal Medicine, Pediatrics, Obstetrics-Gynecology and General Practitioners. 58-bed fully accredited general hospital with 91-bed addition recently completed. Modern new office space available. PW-20

Pediatrician, Internist, and ENT specialist to join a well-established group practice in a community of 40,000 in East Alabama. The community has a 125-bed accredited hospital, 32-bed extended care facility. Good transportation on interstate with quick access to metropolitan area. Will pay travel expense for interview. PW-20-1

Opportunity for ENT, Internal Medicine, and Orthopedic Surgery practitioners to join partnership at clinic located in city of 38,000 population in trade area of 150,000 population in northeast Alabama. PW-20/2

Position for full-time industrial practice at textile plant with 2,400 employees at Decatur, Alabama. PW-20/3

Opportunity for physician interested in joining a progressive public health tuberculosis control program working in Birmingham, Jefferson County. Provide outpatient medical services and some administrative duties. Fringe benefits and salary open. PW-22

Obstetrician-Gynecologist—

Excellent opportunity for a trained Ob-Gyn man who would join a three-man partnership practice in city of 30,000 population located in southwest Alabama. Salary is proposed for the first 12 months, a limited partnership to begin at the end of twelve months, and full partnership to begin at the end of 24 months. PW-25

General Practitioners—

Opportunity in town of 4,000 population in trade area of 50,000 population, located within 100 miles of two metropolitan areas in south Alabama. Industrial and farming area. 44-bed hospital. Office space and equipment available in new building with another physician. Several churches, schools, and service clubs. PW-1

For community of 1,500 population located in south Alabama near city of 12,000 population. Hospitals located within 25 miles. Office space and equipment available. Farming, cattle and textile industries in the area. Several churches and school. Civic clubs and golf courses. PW-1-1

For town of 10,000 population in county of 40,000 population located in scenic mountainous section of Northeast Alabama. Office space and equipment available. Hill-Burton hospital-nursing home. Expanding industries in top agricultural area. PW-1-2

For community of 2,000 population, plus large trade area, located in Southeast Alabama. Modern clinic, fully equipped. PW-1-3

Opportunity in port town of 1,000 plus population in population center of 10,000 located in Southeast Alabama. Clinic available. Hospital located less than 20 miles away. Recreational advantages for water sports. Expanding industrial and farming area. Churches and schools. PW-1-4

For town of approximately 1,000 population in Northwest Alabama, near Tennessee Valley waterways. New 15-bed clinic available. Centrally located near metropolitan areas. Extensive industrial developments. PW-1-5

For town of 12,500 population in trade area of 50,000 located in South Alabama. Nearest large city with population of 145,000 is 80 miles away. Two hospitals with 140 beds. Numerous small industries. Several churches and schools. Recreational activities include water sports and golf course. PW-1-6

General Practitioner to join partnership in town of 3,000 population, plus trade area of 20,000 population in northwest Alabama. Modern office building with six examining rooms. Full partnership at beginning of third year. New 30-bed Hill-Burton hospital. Salary open. PW-1/7

Opportunity in community of 3,000 population with over 8,000 population in trade area, near metropolitan area in northwest Alabama. Clinic and office equipment available. New 400-bed hospital and older hospital. and several nursing homes. PW-1/8

For town of 2,000 population in trade area of 7,000 population located in west Alabama. Physician recently died. Nearest city is 30 miles away. Medical facilities include Hill-Burton hospital and nursing home. Churches, schools, civic clubs, and recreational advantages. PW-1/9

Opportunity for group practice in town of 10,000 population in north Alabama. PW-2

Physician wanted to join 39 year old Medical College of Alabama graduate in a well established general practice in West Central Alabama town. Salary initially followed soon by full partnership. PW-3

Opportunity in community of 5,000 population in trade area of 30,000 population located in northeast Alabama where at present time there are only two active full time general practitioners. Modern of-

(Continued on Page 960)

Physicians Wanted

(Continued from Page 959)

fices or clinic facilities available. 48-bed accredited hospital and 52-bed skilled nursing home adjoining the hospital. Cities of approximately 75,000 population located within 25 miles distance. Agricultural and expanding industrial area. Numerous churches and schools. Country club and golf course being developed and water sports and outdoor activities offer recreational advantages. PW-4

Physician wanted to join well established partnership in Northwest Alabama city of 15,000 population. Two accredited hospitals, junior college, schools, churches, recreational activities. No obstetrics or surgery. New office building. PW-7

For city of approximately 15,000 population in north Alabama, with trade area of approximately 45,000 population. Hospital with over 100 beds, and expansion planned for next year. Nursing homes in the area. Industrial growth and agricultural region. Several churches and schools. Golf course, civic and fraternal organizations. PW-8

For partnership practice in clinic in town of 2,000 population in area of 10,000 population located in north-central Alabama. 40-bed hospital. PW-9

For assistant or associate in clinic located in town of 10,000 population located in northeast Alabama. 65-bed Hill-Burton hospital. PW-10

For associate practice in city of 6,000 population in area of over 10,000 population located in East-central Alabama. PW-11

For solo practice in county clinic located in East-central Alabama. Office, equipment and housing available. 70-bed Hill-Burton Hospital and 22-bed nursing home. PW-12

For town in southwest Alabama, approximately 1,000 population in trade area of approximately 5,000 population, within 60 miles of large city of 35,000. Nearest hospital is located 18 miles away. Arrangements available for office space. Small industries and agriculture. Civic clubs and golf course nearby. Churches and school. PW-13

For town of 1,000 plus population in west-central Alabama in trade area of 20,000. Clinic available. Nearest city of approximately 70,000 population is located a distance of 17 miles. Farming, cattle, timber, and manufacturing plants are principal resources of the area. Churches, schools, and recreational advantages. PW-15

Opportunity for general practitioner to join a five-man group, practicing as a partnership. Each man in the group is either specialized or semi-specialized. The practice is physically located within a 70-bed hospital. Willing to pay qualified person $36,000 for the first year, with possible partnership status in one year. Would consider a physician for locum tenens for three to six months at $2,000 per month. PW-16

For town of 3,600 population in trade area of 5,000-7,000 within 100 miles of two large cities and the Gulf Coast. 50-bed hospital located in the town. Office space available. Agricultural and expanding industrial area. Several churches and two schools. Recreational activities in the town as well as nearby—golf course, hunting and fishing. PW-17

Unusual opportunity for two general practitioners with military obligations satisfied at a modern fifty bed facility located 15 minutes drive from largest metropolitan center in north-central Alabama. Construction of a new two-story office building is scheduled to begin soon. PW-18

Opportunity in city of 5,000 population located in Northeast Alabama in trade area of approximately 10,000 population. Office space available. One physician died recently. Hospital and nursing home in the city. PW-19

Physician Looms Large in Panoramic Educational Picture

It is not necessary to belabor the issue of the importance of the physician to our public schools. From prenatal care to preschool examinations and vaccinations right through to college infirmaries, the physician has always been an integral part of the educational system. Moreover, when one pauses to consider the countless hours given by physicians on county and city school boards in practically every county, town, and city of this Nation, the vision of the inextricability of the physician from our school systems looms sharply into focus. It is with this thought that I submit to the Journal of the Alabama Medical Association an article published in the *American Journal of Psychiatry* in 1968 and recently in the January, 1969 *Mental Health Digest.*

SCHOOLS ARE OUR COMMUNITY MENTAL HEALTH CENTERS

Studies have shown that we reach at best 5 per cent of our emotionally disturbed children. It may be that the schools are the best place to treat, as well as teach, nearly all emotionally disturbed children.

Custodial Role of the School

The consideration needed to complete the argument that schools are mental health centers is obvious—the compulsory attendance law.

Only immersion in the psychosis, suicide attempts, antisocial behavior, and chaos in our schools could convince the mental health professional of the community mental health mission our teachers are expected to perform. Schools accept children who would find few places in child-shelter institutions; they would be considered too "sick" or "aggressive."



Stonewall B. Stickney

The School as Casefinding Agency

Because of the attendance law, the school has become the only effective casefinding agency, and it may be the ideal casefinding agency for disturbed adults with school-age children.

The services described in the literature on comprehensive mental health planning are being performed by many schools. Federal and State funds earmarked to support such services should also go to school mental health programs and not be squandered in trying to approximate such services by reinventing them in a new community mental health center.

Schools have been placed by law and circumstances in the position of having to take care of most of the emotionally disturbed children. But the schools have been granted no special facilities nor have teachers been prepared for such a responsibility, nor have public funds been forthcoming to ensure facilities and training of teachers. A school mental health program must find funds to train teachers and administrators for their mandated mental health functions; find mental health consultants to carry out the training; and find the space, specially trained teachers, materials, and methods to contain, teach, and help the emotionally disturbed children within the school system.

The mental health consultant must be prepared and available to provide crisis consultation service, in addition to inservice training and screening and supportive visits to schools having the special containment "spaces," i.e., classes for emotionally dis-

turbed children. Without inservice training of teachers, a school mental health program will be so busy with crises that no prevention program can develop. The same reasoning applies to classes for emotionally disturbed children. "Clinical diagnosis" does not seem to offer much help, yet this is what has often been offered by mental health teams in school systems.

The psychiatric consultant is a resource too scarce to be spent on clinical diagnosis and direct interaction with students or parents. He must multiply himself by training everybody he can, mainly teachers, to be both casework informants and therapeutic aides.

The Pittsburgh Program

In 1965 the Maurice Falk Medical Foundation gave the Pittsburgh public school system a three-year grant for a school mental health program. In the first year our staff consisted of a coordinator, psychiatric consultant, and director on half-time. The second-year staff included the coordinator and consultant full-time, another psychiatric consultant half-time, three social workers, a secretary, a research associate, and a clerk. The staff also included 12 teachers and aides to work with emotionally disturbed children.

The first year could be described as the phase of hazing into the school's complex subculture. In getting acquainted with principals, teachers, home and school visitors, psychologists, and counselors, we were developing and refining a method of consultation.

All referrals are relayed to us via the principal. We learned that without the informed consent of the principal any diagnosis or treatment plan would be irrelevant and ineffectual. We learned that the school social worker must be informed of, and consent to, the referral. By the time a referral reached our coordinator, it was a joint referral no matter who had originated it.

When we arrived at a school the principal made available teachers who knew or had taught the child to be discussed. Each consultant was teacher-centered, with primary interest and credence granted to the teacher's firsthand observations of the student and his family. The focus shifted to the account of the home visit by the school social worker, with data on birth, health, family history, etc. Data were then elicited from the psychologist.

The consultant would then depart from the passive psychiatric stance and say, "I think all this adds up to such and such difficulties in the home, school, or behavior of the child. And I think we should try this with his family, that with his schedule, and arrange time for Mr. X to work with him on these difficulties." The most important part came when the consultant said, "I'll be back next week to see if anything we decided today made sense. If it didn't we'll revise our plan."

These statements are the hallmarks of a good consultant. He hears everyone out who knows the child, makes his best clinical guess about the sources of difficulty, states a plan, and assures his informants that he will be back to revise whatever was erroneous. Educators can perform a service to psychiatry in gently, but firmly, insisting to each new consultant that he is not to leave the building until he has met all three requirements. School consultants must be trained on the job. Their psychiatric residency and clinical experience do not prepare them for the complexities of school consultation.

While listening to the faculty describe the child, the consultant is alert to several questions. "Who shall help the child?" If the child has found anyone to depend on or confide in, from the custodian to the principal, this choice is honored. The psychiatric and social work consultants become supporters of, and consultants to, the elected adult, who will be the primary therapeutic link with the child. A similar approach is used toward the parents. If nobody has been elected, the consultant helps the group choose the best person. There are many parents and children who will confide in a teacher but will not go

(Continued on Page 967)



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or here.



ed). Though generally not recommended, if ombination therapy with other psychotropics ems indicated, carefully consider individual harmacologic effects, particularly in use of potiating drugs such as MAO inhibitors and henothiazines. Observe usual precautions in resence of impaired renal or hepatic function. aradoxical reactions (*e.g.*, excitement, stimulaon and acute rage) have been reported in psyiatric patients. Employ usual precautions in eatment of anxiety states with evidence of imending depression; suicidal tendencies may be resent and protective measures necessary. Varible effects on blood coagulation have been ported very rarely in patients receiving the rug and oral anticoagulants; causal relationhip has not been established clinically.

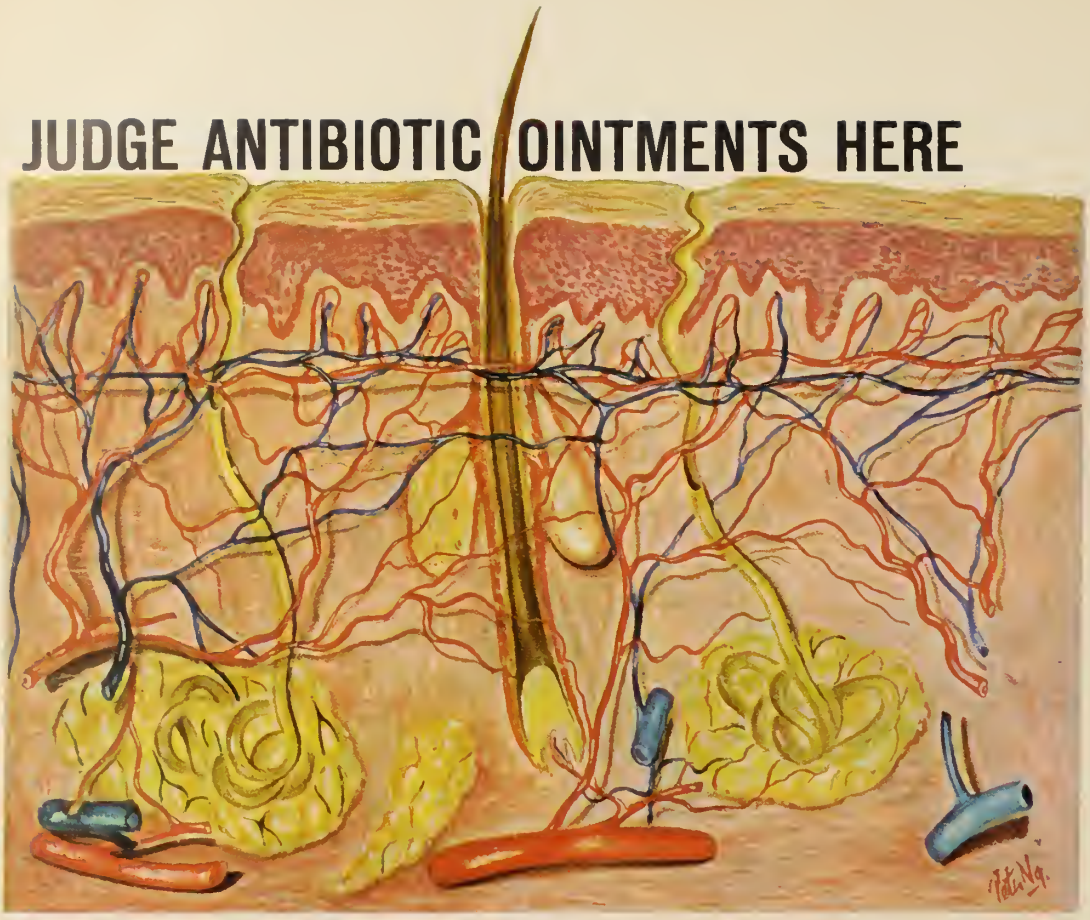
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(Continued from Page 962)

near a counselor, social worker, psychologist, or least of all a psychiatrist.

If the consultant has survived the crisis consultation, he has time and opportunity to provide inservice training for teachers by weekly case seminars. The consultant meets with 10 or 12 teachers to discuss particular children they are concerned about. This criterion, "concern," is sufficient. If the teacher sees enough distress in the child or parents to feel concern, this is sufficient cause to discuss the child.

The learning in these seminars is slow, intense, and as much visceral as intellectual. Texts, poems, plays, and rarely, case histories are introduced only as called for. Psychiatric labels and other nonsense of a generalizing and mystifying sort are avoided.

The hope is that teachers can become more informed, purposeful, and effective therapeutic agents with children. Their therapeutic function has always been inseparable from their didactic role, so it is not a question whether or not teachers will perform therapeutically. The goal is that learning—emotional, scholastic, or social—will be fostered and strengthened in a school that becomes a therapeutic community.

For the more seriously disturbed children we must construct small therapeutic milieus inside, and freely communicating with, the larger school environment. These have been described as special containment spaces because their first purpose is to contain those children whose behavior is uncontainable in regular classes. This criterion screens in mostly the clamorous, aggressive, or openly bizarre children. A later development is referrals for behavior that is depressive or withdrawn.

We do not attempt to change this sequence, having learned that whatever we do must be felt by principal and faculty to be practical, helpful, and fitting their needs. Most teachers learn to be as concerned about withdrawn children as they are about others. Once a school has been relieved of its most difficult burdens, it has more patience and time to devote to individuals.

Children are not stored in these special classes. They are filtered through them at a rate commensurate with their needs and conducive to their early reintegration into regular classes. The teachers have been selected because they are good teachers first, and have shown talent in dealing with difficult children. The teacher likes children, is affectionate and humorous but firm and consistent, and is relatively shockproof and nonpunitive. To these qualities we add special training and regular consultative support, but these additions are not intended to transform teachers into psychotherapists.

Our special teachers are instructed to approach students coming into the program by offering help with school subjects. Almost always the disturbed child is also having learning difficulties, so that the offer is not seen as inappropriate or threatening. He learns that this teacher has the time, patience, and skill to help him with emotional and social as well as academic learning. Many children, especially adolescents, will accept help from a teacher but from no one else. We have learned not to retain a troubled child in school when that child is trying, consciously or unconsciously, to be expelled so that he can be removed from an untenable home situation.

The Ecological System of Diagnosis

The dilemma of the child who needs to be expelled brings up another issue, the philosophy of psychiatric diagnosis. With these "squeezeout" children, the relevance of the child's diagnosis diminishes in proportion as the pathology of the family and of the school increase. The only practical model becomes an ecological system in which the intrapsychic factors are noted but are only a part of the complex total diagnosis. It must include a description of the two ecological niches, home and school, in which the child must establish himself and grow. If he is in

danger of being excluded from either, the child's condition is serious, regardless of his clinical diagnosis. On the contrary, a child with psychosis, brain damage or other serious clinical diagnosis may have a benign condition if home and school are receiving and containing him, and fostering his growth. It is apparent that our biggest diagnostic hiatus is in the area of learning impairments, be they emotional, social, perceptual-motor, or whatever.

We are beginning to meet this need by providing diagnostic screening for all exceptionalities (including talents and strengths) in all children in special and "readiness" classes. When we have funds, we plan to screen all children before they enter first grade. This will be our first truly preventive effort of a sort that can be demonstrated, tested, and found effective or ineffective within a few years. If we succeed in reducing only the incidence of school "failure," we might show that this one change could lower appreciably the numbers who decline rapidly—from failing, to dropping out, to delinquency, and to various severe social-personal patterns of failure and illness.

The final phase of our program is collaboration with schools of education in training teachers. Most new teachers are not prepared to deal with classroom management, much less to deal with disturbed children and families. Our hope is that we can devise training methods that will prepare teachers for life in our schools.

The School as Coordinator of Community Services

There is much to be done while the school mental health program is working toward long-term goals. The uncoordinated nature of interagency collaboration with referrals, re-referrals and reevaluations of children may have a chance for resolution. Every time a conference is held concerning a child who is known to a community agency or who may become involved with such services, all relevant agencies are invited to send a delegate to the conference. The delegates do participate, and often we arrive in one session at a general agreement that usually requires weeks or months via the ordinary modes of communication.

The school seems to be a natural, neutral, even friendly ground for all interested parties to meet upon in a mutual effort to help a troubled child. We hope to demonstrate by such collaboration and by school-centered methods of child, teacher, and family reeducation that our schools are indeed our natural community mental health centers.

Noise as a threat to health is the subject of a two-day conference in Chicago April 28-29, called by the AMA. Increasing concern about "noise pollution" prompted the conference call from AMA's Council on Environmental and Public Health, and the subjects will include noise-induced hearing loss, effects of noise on sleep, noise sources, psychophysical and sociometric aspects of noise, role of the physician in workmen's compensation cases involving noise, control and prevention of noise, and facts and myths about effects of noise on human physiological system other than the auditory system.

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Do You Ever Ask Yourself: What Has AMA Done for Me?

The article which follows was written by David B. Weihaupt, member of the Division of Public Affairs of the American Medical Association.

It should be required reading. Hundreds of times I have been asked "What does the A. M. A. do for me?"

Generally the physician who asks this question does not really wish to know—he just wants to voice his objection to some particular decision or against some established policy of the A. M. A. As you may recall, the House of Delegates creates the policy of the A. M. A., which is implemented by the Board of Trustees and the Executive Staff. Policy is decided by hundreds of *hard working, dedicated and knowledgeable physicians* whose views may or may not agree with yours or those of your *delegates.*

The American Medical Association is undergoing a study of its own organization and administrative management by an internationally known firm of management consultants.

These are critical times for medicine, for YOU and for ME. By carefully studying this most excellent release you will be supporting American medicine.

Your Delegates will welcome your criticisms and suggestions.

M. Vaun Adams, M. D.

Dr. Weihaupt's article follows in full:

David B. Weihaupt

As you know, and as I well know, the questions are asked many thousands of times per year by physicians—What is the AMA doing? What have they ever done for me? What's going on at 535 North Dearborn? What am I getting for my dues?

I think these questions are rightly asked, for a membership card in the AMA does not automatically endow its holder with a sophisticated knowledge about the functions and purpose of the AMA. I do believe that the answers to these questions are available, throughout the course of the year, but they're supplied in a piece-meal basis of letters, pamphlets, and literature that come through the mail, most of which, physicians do not have the time to read, as you well know. I am offering the correct information, facts and figures about the American Medical Association and what it is doing for you, the public, and for the nation as a whole—the truth, if you will. I hope you accept what I say, as well as many people apparently accept the fallacies printed about us in local newspapers and national magazines. I am confident I can prove to you that the AMA is a tremendously functional and productive Association doing an enormous job in serving the profession and the people of this country.

In the following information, I would like to ask you to read into the facts and figures, the benefits that you have and will derive from what we're doing. The general purpose of the Association, is of course, to promote the science and art of medicine and the betterment of public health. I think the following will prove that this is the truth.

I will not defend, apologize, or excuse AMA, its policies, or philosophy, which may be different from yours, or the lost battles of the past.

Now let me give you the following information and facts, not in the expectation that you will remember them, but in hopes that you will comprehend the whole picture and carry it in your philosophy to your community, your friends, and physicians of your county medical society. These figures come from the AMA and not through your local newspapers.

A. There are approximately 317,000 physi-

cians in this country, of which 215,000 are AMA members.

B. Of these, only 164,000 are dues-paying members and not all are full dues-paying members.

C. Approximately 28% of our total budget is from physicians' dues. The remainder we have to plan, program, and work for through our advertising and exhibit revenues.

D. Your dues of $70 would have to be over $220 to make up the needed funds to operate if it weren't for the abilities and the hard work of the people at AMA in obtaining these revenues.

E. Approximately $5 million of the budget goes for salaries for the 922 employees. In this group are physicians, attorneys, chemists, journalists, biostatisticians, and accountants who are high calibre people.

F. We have real estate taxes of approximately $275,000 and social security payments of approximately $350,000.

The AMA is one of the world's largest publishers, and about $12 million of our budget goes into paper, printing and mailing. I ask you to consider all the following figures on a basis of a cost of 11c per page to produce and mail. These costs, by the way, are up approximately 181% in the last seven years. I would like you to consider the following as benefits not only to the general public, and AMA members, but also as benefits derived by non-members, for AMA serves the profession, as a whole.

1. Since 1960, over 3 million pieces of literature have been sent to students of medical schools.

2. The AMA NEWS has a circulation of approximately 340,000 and is published each week. That's about 17 million newspapers per year. Each physician, member or not, members of Congress and major newspapers all over the country receive copies.

3. We have approximately 3,500 different pamphlets—child care, health education, health tips, sex education and many others. We send out over 100,000 copies per year of each of the major pamphlets and thousands of the others.

4. We have sent out over 2 million copies of the AMA First-Aid Manual in the past several years.

5. We publish 10 specialty journals with a circulation of 226,000 and we recently released 311,000 pieces of mail to physicians in this country on health education materials.

6. Every two years, we publish the AMA Directory, 6,500 copies, which contains biographical and educational data on every licensed physician in the United States. It is a three-volume set and they are sent to every state and county medical society, all journal editors, and the libraries of 94 medical schools.

7. The magazine "Today's Health" comes out monthly with a circulation of 700,000 each month, a mailing of about 8½ million magazines each year.

8. "Horizons Unlimited" on health careers has been sent in quantities of tens of thousands to schools, colleges, and medical societies, free.

9. In one month, we sent out 30,000 copies of our booklet "Selective Service, Military Service, and the MD," to medical schools and other organizations requesting it.

In addition, you may be familiar with our books "Current Medical Terminology" and "New Drugs," which are sent out by the thousands each year.

10. JAMA, the Journal of the American Medical Association, has a circulation of 219,000, and it comes free to all members of the AMA. This, "Today's Health," AMA NEWS, and the specialty journals cost the AMA about $50 per year to send to each physician member. The AMA specialty journals and JAMA are published by the McCall Corporation in Dayton, Ohio. With all these publications and materials distributed, the mem-

bers of the AMA carry some of the burden of the non-members.

11. Each year, thousands of manuscripts are submitted to us for review, and actually, we are able to publish over 1,000 each year.

12. We check over 500 medical publications each month for useful information to relay to you through our publications.

13. In 1967, over 25,000 copies of "Winning Ways With Patients" were sent free.

This is actually a small percentage of the tremendous publishing, printing and mailing burden that we have every year, and this is done for the benefit of the public, the medical profession, component societies, and other organizations in the country. The natural question is—Why all this paper?

The reason is that these publications have been asked for by the 242 members of the AMA House of Delegates, by the public of this country, the schools of the nation, allied health professions and health institutions, and also the more than 1,900 state and county medical societies. We publish these materials as answers to the needs of these organizations. As a result of the asking by these organizations, we research, plan, design, publish, print, and mail these tens of millions of pieces every year. Literally thousands of pieces of different types of material are relayed to your component medical societies. Information on legislation, state laws, federal laws, plans and programs of the AMA, and just normal everyday correspondence between component organizations. I realize this is a lot of time, work and a lot of paper, but this is the responsibility of the AMA to the people of this country, and it is a responsibility that we must keep, or would you have us yield and give this job to someone else—shall we say, industry, state government, the federal government, or labor. Who else but the AMA is more qualified, more dedicated, more capable and more unbiased to do this job for the physicians and the people of this country —and the job must be done.

I gave you small packaging of the total statistics available and what actually goes out of the AMA. Now for some of the things that come into the AMA.

1. In one day, there are 1,000 long distance and many more local calls coming into our office.

2. Over 21,000 pieces of first class mail are handled by the AMA every day. This is about 6 million pieces of mail every year. Consider the fact that to serve membership and the public, it takes people to receive, open, distribute, reply to and file this enormous load of correspondence.

3. Each year, we receive 30,000 requests from the general public for help and information, and we get many thousands more requests for information and help from physicians, the profession—not just members.

4. In our card catalog of physicians, there are 6,000 changes every week in physicians' home and office addresses.

5. The Archive Library of the AMA handles in an average month:

A. 2,400 research requests

B. 750 requests for books

C. Loans of 400 library items

D. Photocopying and mailing of approximately 19,000 pages of material

E. 40,000 books in the Library itself

F. 2,500 periodicals

G. 610 magnetic tapes with medical information

H. In the film library, there are 500 films, available to the public, medical societies and the individual physician to be used in learning or speaking. A cross file in the film library has over 7,000 cards. Although you may never use these benefits, tens of thous-

ands of people do each year, and will in the future. They are available for you.

6. The film "Medical Careers" has been shown 90,000 times and the film "Careers Unlimited" has been shown over ¼ million times. A new film called "Faith" is being made and publicity spots have been sent out to over 2,000 radio stations. Recently, we sent out health tips to over 600 TV stations and 2,600 radio stations—a 60 second spot, for the public benefit.

7. In the past year, we have arranged for over 1,300 health films to be shown 32,000 times at 7,000 appearances before 13 million people.

Conceivably these are very boring figures, but if you consider them carefully, you will see the enormous job that the Association is doing in almost all fields of medicine. It would be a wonderful thing if the general public and physicians had an awareness of this enormous job. Then, the many misconceptions about the AMA would most certainly be cleared up.

8. We have designed and built 110 medical exhibits for use by the public, medical societies, and medical schools. Some of them were at the Kentucky Medical Association Annual Meetings last year and this year.

9. I am sure many of you are familiar with the page, the "Legislative Roundup" which goes to all state, county medical societies, and physician leadership in the states. It is a one-page piece with a brief summation of the status of current legislation in Washington.

10. It is hoped that in the near future, we can initiate a new program called "Report of the Nation," which will be a coast-to-coast one-hour network TV program put on 3 or 4 times a year by the AMA to provide accurate and truthful information to the public. We doubt that we will be able to afford equal time with the President of the United States.

Now I have covered what goes out of AMA, also what comes in. Here is more information on what goes on in the AMA. Considering the preceding, it's possible that these questions have already been answered. But let me continue.

1. There are over 1,000 meetings held every year and over 800 physicians serve without pay on the 80 commissions, councils, and committees. That's one physician for every 200 in the country. There are 80 committees, 16 councils, 4 commissions, 22 scientific sections, 10 specialty journals, 50 departments and 8 divisions, which are the Communications Division, Law Division, Management Services Division, Scientific Activities, Scientific Publications, Health Service, Medical Education, and my Division, Field Service. Under these are the Council on Drugs, Committee on Quackery, Committee on Cutaneous Health and Cosmetics, Committee for Research on Tobacco and Health, and on and on to a total of 80. All of this was created by the actions of the House of Delegates, for the needs of medical societies, the general public and the profession.

2. Throughout the course of the year, we sponsor 400 scientific lectures, 400 scientific exhibits at the Annual and Clinical Sessions and 300 exhibits on New Drugs. There were 39,000 registrants at the 1967 Annual Meeting in Atlantic City and these people had an opportunity to see the latest developments in American Medicine.

3. I am sure you have heard of the AMA-ERF Student Loan Program, sponsored by the AMA. Under this program, the AMA has arranged over 45 million dollars in loans, involving 28,000 separate loans to 19,000 medical students, interns and residents. In Kentucky alone, we've arranged over 852 loans encompassing over $963,000.00 to your medical students. The average physician contribution in this country is $2.50. Since 1955, we have received and distributed over $35 million to medical schools in this country. We have Councils and Committees who are also working very hard to increase the en-

rollment in medical schools, expansion of the facilities of those that exist, plus assisting in the forming of new medical schools. Sixteen are now in the making, and AMA has made major contributions to their beginnings.

4. Woman's Auxiliary, with headquarters at AMA, has received and distributed over $3 million for medical schools and $4 million to the Student Loan Program.

5. We have also available some direct benefits, such as the AMA Retirement Program and the Disability Program that physician members can take advantage of.

6. Our Speakers' Services Department writes and supplies speeches and other materials for research for physicians throughout the country and officers of the Association. We also supply building plans, partnership agreements, and a variety of other services are at the disposal of physicians.

7. Our Communications Division has literature, program aids, films, speeches, press materials, and other services available to state and county medical societies, as well as physicians. For the Director of the Communications Division, there is an advisory committee which consists of state executive secretaries. Mr. Joe Sanford was a member, who lent a respected voice to this Committee and their programs for many years till his recent untimely death.

8. The Department of Medicine and Religion consists of a four-man staff working with medical schools, theological seminaries, hospitals, physicians and clergy in a very successful attempt to bring together the healing of the body and soul.

9. As I mentioned earlier, there are over 1,000 meetings held by AMA each year. Just to give you an idea of what these meetings are week to week, beginning June 10 through June 17, the following were scheduled:

A. Regional Workshop for State Chairmen of Medicine and Religion

B. Committee on Planning and Development

C. Conference Committee on Graduate Training and Surgery

D. Symposium on Exercise and Heart

E. Residency Review Committee on Neurological Surgery

F. Committee on Environmental Health

G. Committee on Aerospace Medicine

This schedule of meetings goes on 52 weeks a year including weekends, once again to serve the purpose of advancement of the science and art of medicine and the betterment of public health. These and all others cannot be eliminated for we would sacrifice not only the well being of the profession and public health, but the leadership of the physicians in medicine.

10. Undoubtedly, you have heard of the American Medical Association Institute for Biomedical Research. This was created by the AMA House of Delegates. There are 30 scientists doing research in immunology, medical ecology, virology, molecular biophysics, regulatory biology and neurobiology. This, too, is a service to all mankind.

11. Project Viet Nam is a program initiated by the federal government, which was not functioning too well, naturally, and the government asked the AMA to take it over, naturally. It is a program whereby physicians volunteer to go to Viet Nam and serve the civilian public of that nation. In two years since we have been handling the program, approximately 293 physicians have served in Viet Nam. Last month alone, we had 75 inquiries and 28 applications were filed. This month there were 9 physicians going to Viet Nam to serve under this program.

One of the most active divisions of the AMA is the Law Division which supplies to

all departments and the Board of Trustees and the physicians throughout the country, legal opinions, guidance, information on medical liability, taxation, insurance, advertising, copyrights, and specific information on libel and slander. Thousands of physicians write every year and receive guidance on state problems, retirement problems, partnership agreements, and federal and state laws. Under the Law Division, the Department of Investigation wages a relentless battle against quacks and charlatans throughout the country, as a service to the public health and the profession.

12. Let me briefly give you the box score of the AMA Political Action Committee, which was involved in 131 Congressional races in 1966. Of those, 104 races were successful. They were involved in 15 Senate races, and won 13 of them, and some of these major victories were made in the state of Ohio as a result of the tremendous and effective effort of your Ohio Medical Political Action Committee.

And now, after all this information about the AMA and its services to the physicians and the public of this nation, I would like to discuss that which the press dearly likes to write about as a major and almost total function of the AMA—The Washington Lobby.

Some say all they do is try to enhance the income of physicians of this country. They write about this group, the Lobby, as a huge multi-million dollar organization—those, who it is written, hate children, old people, the unborn, handicapped, and the poor. This is a huge, unjust burden which we carry. When this Lobby tries and succeeds in excluding the disabled persons from the new social security amendments, the press of this country generally says that the physicians hate the handicapped. In truth, these unfortunate people are not only treated free or at a decreased charge by physicians, but they're also covered under Title XIX of Medicare, and several other federal and state programs. This is a prime example of federal duplication. Only a fraction of one percent of the budget of the AMA goes to lobbying. Let me tell you more about this so-called multi-million dollar lobbying staff. In truth, it consists of four full-time registered lobbyists. Yes, we have only four men in Washington compared to Labor's 125 registered lobbyists and 300 unregistered lobbyists. Each of our four men has 12 senators and approximately 110 congressmen to learn about, work with and convince. A small force indeed. But don't let me minimize their abilities, their influence, their effectiveness and their successes. They do an outstanding job and this can be proven by our past and present successes in Washington. It can also be proven by some of the adverse publicity that we get. There were some rather uncomplimentary quotations in one of the nation's leading magazines not too long ago. Senator Stephen Young (Ohio) referred to this huge AMA lobby in the November, '67 issue of *Playboy Magazine,* as follows: "One of the slickest, best financed in the nation" and "it has been the spendingest lobby in Washington in recent years." Not only is his choice of words uncomplimentary, but inaccurate.

So you can see, we have immunity nowhere and it is popular to discuss this huge four-man lobby in *Playboy,* adding sophistication to the magazine, and supposedly some degree of credence by quoting Senator Young, though his statements were gross inaccuracies.

Let me give you some information on what this lobbying staff is really up against and what it really does. In the 89th Congress, there were 26,500 bills introduced of which 1,600 had health implications. The AMA of-

fered information and opinions on 33 of these bills, and contrary to popular belief, we favored 21, partially favored 5, and opposed only 7. In the first session of the 89th Congress, there were 850 bills with medical implications, but in the first session of the 90th Congress, there were over 1,126 bills pertaining to health. We have one man in Washington to analyze these bills. Back in Chicago, there are three men to correlate policy and position and testimony on these bills, and to establish a position as to the impacts of the legislation on physicians of this country and the general public. I wish to point out that a great deal of the work done in Washington by our staff is for the benefit of the science of medicine and that these men supply basic medical information to members of Congress, for themselves and for the people of their district. They also help the legislators obtain family physicians when they move to the District of Columbia.

Now, a little about my Division—Division of Public Affairs—The Washington office is part of this Division, and we headquarter in Chicago. There are 12 men covering the United States, also Puerto Rico (The Virgin Islands) and as far away as Alaska and Hawaii. We work in person-to-person contact with staff and leadership of state and county medical societies. I personally cover Ohio, Kentucky and Indiana. A great percentage of my function is in the legislative and lobbying area. In our work, we interpret and promote the activities and services of all AMA Departments to component societies, and, in turn, familiarize AMA with the programs, problems, needs and opinions of component medical societies, and the public, physicians and physician leadership.

But when I am asked "What do I get for my dues?", if I don't have the time to give a speech, my short reply is "Nothing." Who said that the $70 in dues would come back to the member January 1 each year as a short term capital gain? The AMA is not an investment house. The joining of the AMA, state medical association and county medical society is another service that the physician performs not only to his profession, or for the betterment of public health, but for himself. Many physicians do more in their contributions to these organizations, by serving on committees and councils and as officers.

But, let me say this: If all of the preceding information does not convince you of the effectiveness and dedication of AMA to the profession and the people of this country, let me ask you several favors.

1. Read with a critical eye, the newspapers and magazines of this country that mis-shape these statistics and misinterpret our work.

2. Don't quote your enemies, quote your friends.

3. Don't lend your voice to those who oppose medicine, thus adding credence to what they say. AMA and KMA aren't the ones passing the bills and controlling your practice.

4. Don't criticize AMA, county and state societies with inaccurate information, for this assists the enemies of medicine in eliminating the private practice of medicine and organized medicine as we know it today.

The opposition knows we are divided. They are not.

Pamphlet titles recently released by the American Medical Association include:

Your Teenager and Smoking—Cosmetic Surgery—Tetanus, the S e c o n d Deadliest Poison.

In addition, there are two- and four-page essays on: Amphetamines, Barbiturates, Glue Sniffing, L S D, and Marihuana.

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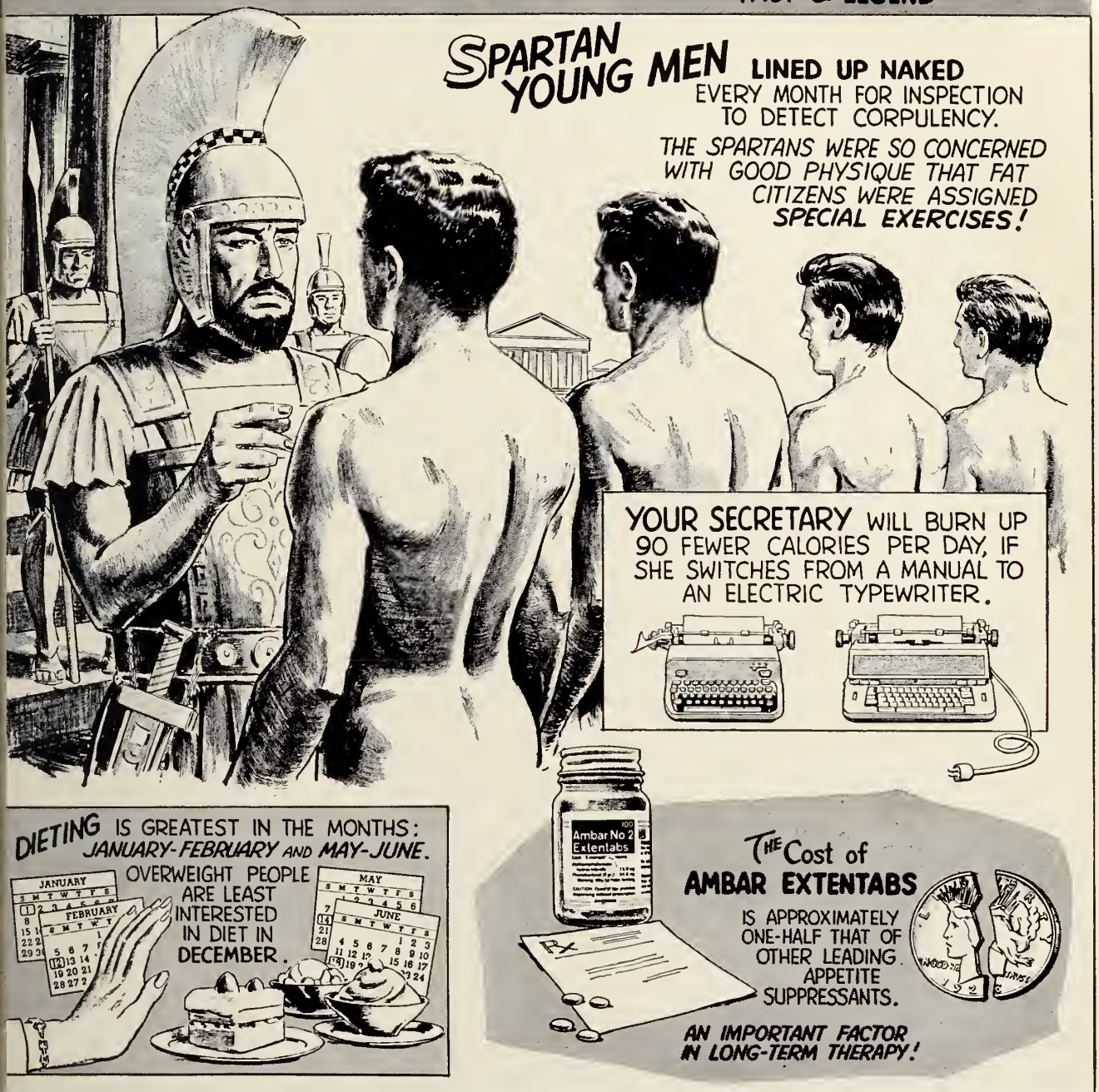
CHARLES W. NEVILLE, JR., M. D., *Assistant Professor of Psychiatry and Medical Director*

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Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.
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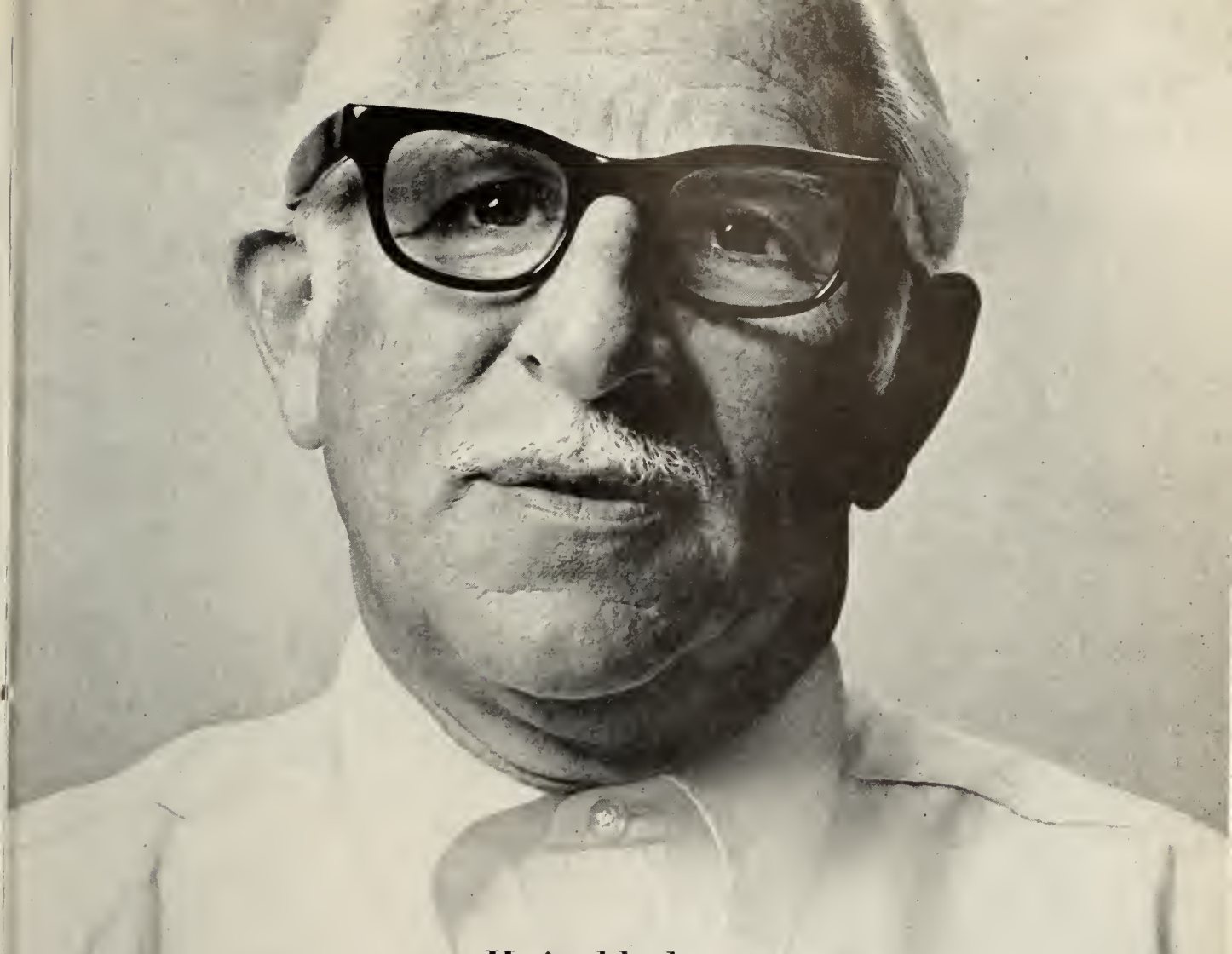
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Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken.

In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

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President's Page



C. Kermit Pitt

Because of editorial deadlines this message is of necessity being prepared before the Annual Meeting and therefore prior to installation of Association officers. Perhaps, this, my first page, might more truly be called the President-Elect's page.

Semantics aside, I welcome this opportunity to express to all members of the State Association my appreciation for the honor of allowing me to serve as your president. I accept the duties and responsibilities with humility and pride, and pledge you dedication to the task. In attempting to make the coming year one of the greatest in the Association's history I will spare no effort.

All of us are aware of the fact that little will be accomplished unless each of us is active in interest and dedication. Therefore I challenge members, committee members, committee chairmen, members of the Board of Trustees and members of the Board of Censors, the Association officers and central office personnel to join me in making 1969-70 a great year for the Association.

Complete elaboration of the goals of my administration at this time is neither possible nor advisable. Some observations, nevertheless, may be made. First, I share the interest of my esteemed predecessor, Dr. E. L. McCafferty, Jr., that each member of the Medical Association of the State of Alabama feel himself to be vital in the organization's operation and progress. Opinions and counsel from all are eagerly solicited.

Secondly, members of the Association and members of the Academic Community are interested in the same ultimate goals, namely, production and delivery of the best possible medical care to the greatest number of people. This is true of the researcher, the clinical teacher and the private practitioner in his office. We are a team which will best function if we communicate and lend helping hands to each other. Toward this end I dedicate unstinted devotion.

Thirdly, the problems of the various federally financed medical programs will continue to demand our attention. Financing the State's share of Medicaid will not be easy but the means must be developed. Medicare, Regional Medical Programs, Appalachia, Head Start, etc. will require our constant efforts to promote the best of them while challenging and attempting to correct the undesirable.

Finally, we hope to be able to successfully deal with the many unexpected challenges which are certain to arise in the year ahead.

C. Kermit Pitt, M. D.

The Woman's Auxiliary

President, Mrs. Ben H. Johnson, Jr.
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Northwest District Vice President, Mrs. Gene Qualls
Southeast District Vice President, Mrs. George Andrews
Southwest District Vice President, Mrs. Andrew D. Henderson
WAMASA Editor, Mrs. William L. Smith

AUXILIARY PLEDGE

"I pledge my loyalty and devotion to the Woman's Auxiliary to the American Medical Association. I will support its activities, protect its reputation and ever sustain its high ideals."

Presidenting the Woman's Auxiliary to the Medical Association of the State of Alabama is an awesome responsibility. Doctors' wives have done so much to promote better health in Alabama; and the wonderful women who have preceded me in this office have through their leadership presented to all of us a tremendous challenge.

Membership is our NUMBER ONE priority. We need every married doctor in Alabama to ask his wife if she is a member of the Auxiliary, and if not, please urge her to join us in our program. Also we ask help from the County Medical Societies in the counties where there is no Auxiliary to support us in our efforts to organize new ones. Our program has so much to offer all doctors' wives, and we need them in our Auxiliary.

There will be special emphasis on AMA-ERF and the increasing need for our funds makes this a major project. AMA-ERF County Chairmen all over Alabama will be working harder than ever to raise money for our medical schools. We ask again that the doctors send in their contributions through our Auxiliary. Alabama is *fourth* nationally in amount of money sent in per member, and we were told by the National President at our Convention last year that we do the best job of channelling our funds to our own medical school of any State Auxiliary.

Society today is greatly influenced by "Youth Power" and the Woman's Auxiliary to the AMA is continuing its "Accent on Youth" in the coming year. In order to follow this program in Alabama we have combined the Committee on Community Health with Children and Youth. Our able chairman will work in this area as it is set up by the National Board of Directors.

Mental Health will receive special emphasis for all over Alabama citizens are becoming increasingly aware of this illness. The new Mental Health Hospitals and Clinics offer opportunities for service to our members. Legislation and Health Careers hold important places in our program.



Mrs. Ben H. Johnson

When I attended the Regional Conference in New Orleans in October, 1968, there was discussion of the relation of the Medical Societies in the various states to the Auxiliaries. I was very proud to find that we enjoy better relations than many others in our region, and we are the only Auxiliary in the Southeastern Region that is privileged to contribute a page in the monthly medical journal.

We are willing to help the Medical Association of the State of Alabama in any way that we can. Won't you call on us, for we would not be able to carry out our projects or to finance our program without the wonderful support we enjoy from you. And for this we thank you.

Ruth Johnson

(Mrs. Ben H. Johnson, Jr.)
President, WAMASA



"June" McCafferty Made The Medical Association A Great President

Individuality, at the same time the distinction and the despair of the medical profession, is the eternal challenge to all leadership in medicine.

The way in which Emit Luther McCafferty, Jr., immediate past president of the Medical Association of the State of Alabama, met that challenge is the spotlighted feature of his administration.

The basic purpose of the organization he has headed for the past year is to unite for the common good of medicine. He has proved himself conspicuously fitted for the task, with a capacity for seeing all sides of any issue, weighing the facts, making decisions, speaking frankly, honestly, but tactfully, and so winning the confidence of all sides.

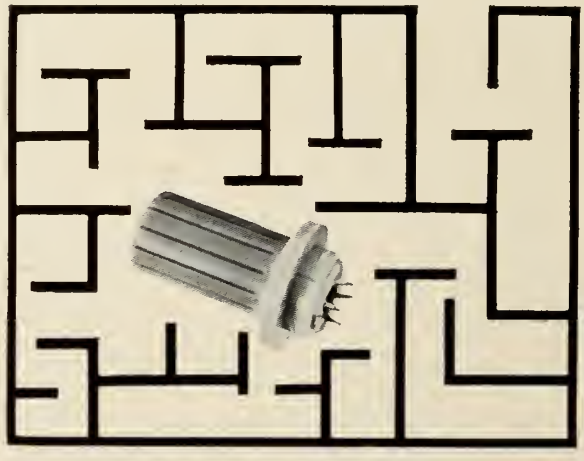
At the same time—and this is a factor not to be ignored—his has been an inate loyalty. He brought committees of the association into closer relations with the Board of Trustees and, through it, with the Board of Censors. He insisted on chairmen making periodic reports. And finally none will remember an instance where he failed to side with his committee chairmen when the chips were down.

Through the twelve months of his administration he showed great foresight, looking ahead to problems of the future, and trying to correct little problems before they became big problems.

He recognized the geographical differences of the state and, with a meeting of the Board of Trustees in Florence initiated an idea that might be commended to MASA Presidents of the future.

He worked diligently to eliminate misunderstandings and bring into closer harmony the paramedical groups—the hospitals, medical assistants, nurses, keeping personal contact with them at meetings and semi-official functions—so that MASA's relations with them are closer than ever before.

In brief, "June" McCafferty "kept his cool" and made a great president.



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Meet The New President of The Medical Association of The State

Alabama doctors have gone from one end of the State to the other, from Congressional District No. 1 to Congressional District No. 8, in the selection of 1969's president of the Medical Association of the State of Alabama.

C. Kermit Pitt, M. D., was born in the same county, Morgan, to which he returned with his M. D. degree from Tulane to take up the practice of pediatrics. And the way in which he has entered into both the professional life of his state and nation and the civic life of his community and state is best reflected by the record:

He is a Diplomate of the American Board of Pediatrics, a Fellow of the American Academy of Pediatrics, a member of AMA, of the American Thoracic Society, a charter member of the American Society of Adolescent Medicine, an Assistant Professor of Clinical Pediatrics, Medical College of Alabama, a past president of the Morgan County Medical Society, of the Decatur General Hospital (and Chief of Staff), and of the Alabama Pediatric Society, and a member of the Morgan County Society's Board of Censors.

In a blend of his professional and lay leadership, he is a trustee and member of the Blue Shield Executive Committee of Alabama Blue Cross-Blue Shield.

And for his contributions to his community and his state, he is vice chairman of the Tri-County Appalachian Commission, a past member of the board of directors and past president of the Decatur Civitan Club, a past president of the Decatur Country Club, a past director of the Decatur Boys Club, a past director of the Decatur Youth Baseball Association, a past director of the Decatur Chamber of Commerce, and 1966 Morgan County United Fund Campaign chairman.

A member of the First Baptist Church of Decatur, he is married to the former Zelda Thompson and there are three children.

There Are Two Kinds Of Doctors In Alabama Today

We can divide— and we *do* divide—people into all kinds of categories.

There are good people and bad, sick people and well, colored people and white, practical people and dreamers, the learned and the unlettered, inlaws and outlaws; there are all kinds of categories, even including doctors and non-doctors.

Every M. D. who is a specialist—and with the General Practitioner very properly recognized today as a specialist, all licensed doctors qualify—knows there are degrees of difference in every category.

"Pressure groups" are where the practical separate from the dreamers. And until eight years ago, the medical fraternity, collectively, could have been classified on the side of the dreamer. AMPAC (the American Medical Political Action Committee) and its 50 PAC organizations at a state level were yet to be born.

In the medical fraternity the dividing line between the alert and the asleep is a dim, uncertain thing. With few exceptions, the doctors of Alabama are members of the Medical Association of the State of Alabama. But, as of last year, only one out of every four doctors in Alabama belonged to the alert, practical wing of MASA—to the Alabama Medical Political Action Committee, ALAPAC.

Some excused themselves to their friends in ALAPAC by objecting to an isolated decision of ALAPAC in candidate support; some still flinched from the thought that doctors must interest themselves in politics, ignoring the fact that politics was very much interested in them; but, for the most part, they

stayed out because no fellow doctor had bothered to present the facts-of-political-life to them along with an ALAPAC membership application blank.

"Physician, heal thyself," advises a quote from Scripture.

Too often we quibble, as did the little boy innocently. When the stern father agreed, "You may ask your question, but be brief," he replied:

"Well, when a doctor gets sick and another doctor doctors him, does the doctor doing the doctoring doctor the doctor the way the doctor wants to be doctored, or does the doctor doing the doctoring of the doctor doctor as he wants to doctor?"

Although the line between them will be wavering—this year especially—we may divide the doctors of Alabama into two decisive classifications:

Those who belong to ALAPAC—and those who do not.

They Say That "Imitation Is The Sincerest Flattery"

On the staff of every metropolitan newspaper is at least one trained rewrite man. On his desk when he goes to work, are clippings of features from rival newspapers.

His first responsibility with each clipping is to seek "new angles" to the story or developments that the original writer has overlooked. Whether he finds them or not, he must rewrite the story so that it seems entirely new, completely different.

And any trained newspaper rewrite man can do precisely that.

Remembering that, remembering the Biblical observation out of Ecclesiastes that "there is no new thing under the sun," isn't it a pity (from the standpoint of the profession) that the so-called expert in the Sirhan Sirhan case didn't bother to rewrite the central theme of his "expert" testimony?

Every doctor, every lawyer, every minister, every professor is following, every day, in the footsteps of those who have gone before.

Long before he goes into print or onto the speaking platform, he has researched his subject, and either rephrased what he has to say or put quotation marks around where they are needed.

Even among the great thinkers of the past, there is wholesale borrowing, as a quick glance through the 1,600 pages of Bartlett's "Familiar Quotations" reveals in its vast array of footnotes.

No patriotic American has ever criticized Nathan Hale, who stood on the gallows and exclaimed, "I only regret that I have but one life to lose for my country!" for failing to credit Joseph Addison with the thought. Addison, who died seven years before Hale was hanged, had written: "What a pity is it that we can die but once to save our country!"

In 1770, Voltaire wrote: "It is said that God is always for the big battalions." Six years later, Edward Gibbon, the historian, voiced the same idea when he wrote: "The winds and waves are always on the side of the ablest navigators."

When Judah P. Benjamin, later to become the Confederacy's Secretary of War, was serving in the United States Senate from Louisiana, a fellow Senator of German extraction taunted him for being a Jew. His reply: "The gentleman will please remember that when his half-civilized ancestors were hunting the wild bear in the forests of Silesia, mine were the Princes of the earth."

Doubtless he was quite familiar with Disraeli's reply to a similar taunt, some twen-

(Continued on Page 987)

(Continued from Page 984)

ty years before: "Yes, I am a Jew, and when the ancestors of the right honourable gentleman were brutal savages in an unknown island, mine were priests in the temple of Solomon."

Thomas Jefferson in 1807 remarked to Baron von Humboldt: "When a man assumes a public trust, he should consider himself as public property." It is interesting to note that he was borrowing, without credit, almost directly from a statement of Edmund Burke 17 years before, who in turn had appropriated the thinking of Mathew Henry 80 years before that.

Bartlett is full of such illustrations, though generally they changed the wording a little bit.

For its broader application, and perhaps accepting as a generality the thought that "there is no new thing under the sun," how can any modern youth truly speak of "my thing"?

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Dr. J. G. Galbraith, Birmingham, New Board of Censors Member



Dr. James G. Galbraith

Dr. James Garber Galbraith, Professor of Surgery and chairman of the Division of Neurosurgery, Medical College of Alabama, is a new member of the Board of Censors, Medical Association of the State of Alabama, succeeding Dr. Wilmot Shipp Littlejohn.

After years of distinguished service, Dr. Littlejohn decided not to stand for reelection.

Born in Anniston, Ala., May 28, 1914, Dr. Galbraith attended the University of Notre Dame two years before transferring to St. Louis University, from which he received his B. S. degree in 1936, his M. D. degree in 1938. After two years as an instructor in Neurology at Columbia, and wartime active duty with the Medical Corps, U. S. Naval Reserve, Dr. Galbraith went to Birmingham in 1946 as Associate Professor, Neurological Surgery, at the Medical College.

The new member of MASA's Board of Censors is a past president of the Southern Medical Association, a past president of the American Academy of Neurological Surgery, a past president of the Southern Neurosurgical Society, a past president of the Jefferson County Medical Society.



Alabama's First PAC Chairman Becomes MASA's President-Elect

Dr. Buford Word, native Mississippian, Birmingham ObG, currently a member of MASA's Board of Trustees and the first chairman of ALAPAC, is the new president-elect of the Medical Association of the State of Alabama.

Member of the Volunteer Faculty, Medical College of Alabama, he is Councilor for Alabama for the Southern Medical Association, member of the Jefferson County Medical Society's Board of Censors, a member of the American College of Obstetrics and Gynecologists, of the American College of Surgeons, and of the Methodist Church.

Dr. Word was born in Aberdeen, Miss., Dec. 21, 1907, received his Bachelor of Science degree from Birmingham-Southern in 1931, his M. D. from Louisiana State University in 1935, and his hospital training at Charity Hospital, New Orleans. Private practice, which he entered in Birmingham in 1937, was interrupted for service in the U. S. Army Medical Corps iin World War II, resumed in 1946, when he returned to Birmingham to enter private practice in Obstetrics and Gynecology.



Dr. Buford Word

Dr. Word is married to the former Sylvia Riley and there are six children.

NYU Tumor Service 87

The oldest clinical cancer service in continuous existence in the United States, located at the New York University School of Medicine, celebrated its 87th anniversary on April 15th, with ceremonies that included a speech by Dr. Francis D. Moore, Moseley Professor and chairman of the department of surgery at Harvard Medical School. His subject was "A Program for the Treatment of Carcinoma of the Breast."

The facilities of the tumor service are available to physicians at NYU Medical Center, in outside practice, and those affiliated with other groups.

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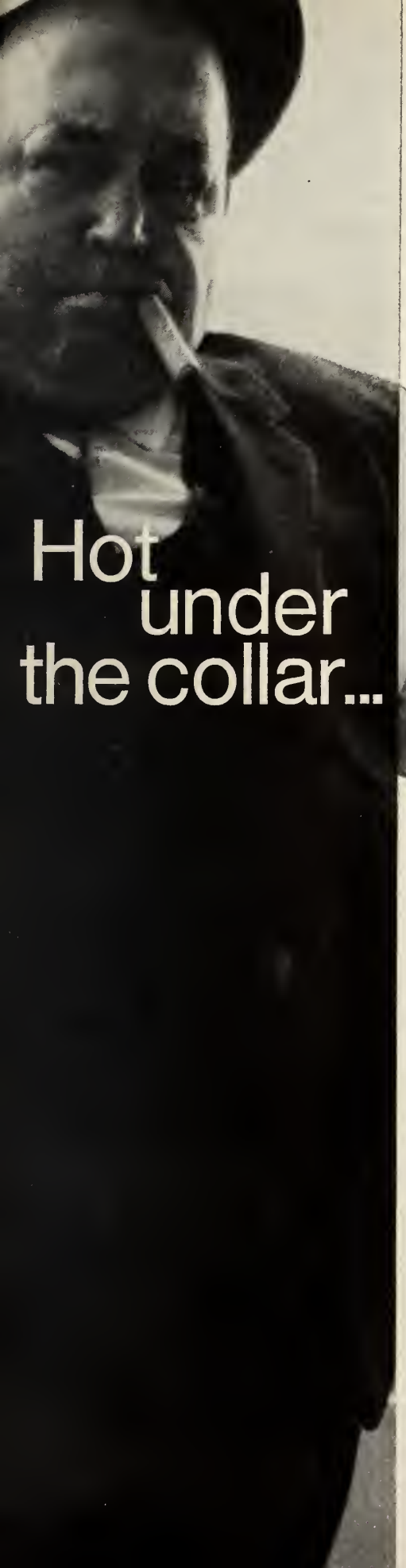
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Indications: Hypertension.
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Warning: With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small-bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has frequently been required and deaths have occurred. Discontinue coated potassium-containing formulations immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Discontinue one week before electroshock therapy, and if depression or peptic ulcer occurs.
Use in pregnancy: Because chlorthalidone may cross the placental barrier and appear in cord blood and thiazides may appear in breast milk, this drug should be used with care in pregnant patients and nursing mothers. When used in women of childbearing age, the potential benefits of the drug should be weighed against the possible hazards to the fetus. Use of chlorthalidone may result in fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult. Increased respiratory secretions, nasal congestion, cyanosis and anorexia may occur in infants born to reserpine-treated mothers.
Precautions: Antihypertensive therapy with this drug should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents, other potent antihypertensive drugs, or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. To avoid hypotension during surgery, discontinue therapy with this agent two weeks prior to elective surgical procedures. In emergency surgery, use, if needed, anticholinergic or adrenergic drugs or other supportive measures as indicated. Because of the possibility of progression of renal damage, periodic kidney function tests are indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated. Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, the drug should be discontinued and potassium supplements given, provided the patient does not have marked oliguria.
Take particular care in cirrhosis or severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Severe salt restriction is not recommended. Use cautiously in patients with ulcerative colitis or gallstones (biliary colic may be precipitated). Bronchial asthma may occur in susceptible patients.
Adverse Reactions: The drug is generally well tolerated. The most frequent side effects are nausea, gastric irritation, vomiting, diarrhea, constipation, muscle cramps, headache, dizziness and acute gout. Other potential side effects include angina pectoris, anxiety, depression, bradycardia and ectopic cardiac rhythms (especially when used with digitalis), drowsiness, dull sensorium, hyperglycemia and glycosuria, hyperuricemia, lassitude, restlessness, transient myopia, impotence or dysuria, orthostatic hypotension which may be potentiated when chlorthalidone is combined with alcohol, barbiturates or narcotics, leukopenia, aplastic anemia, skin rashes, thrombocytopenia, agranulocytosis, nasal stuffiness, increased gastric secretions, nightmare, purpura, urticaria, ecchymosis, weakness, uveitis, optic atrophy and glaucoma, and pruritus. Eruptions and/or flushing of the skin, a reversible paralysis agitans-like syndrome, blurred vision, conjunctival injection, increased susceptibility to colds, dyspnea, weight gain, decreased libido, dryness of the mouth, deafness, anorexia, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Jaundice, xanthopsia, paresthesia, photosensitization and necrotizing angiitis are possible.
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Three Inseparables Of Pre-Med Days Reunited For ALAPAC

More than three centuries after a young Garcon named D'Artagnan rode into Paris on his orange-colored pony to join three musketeers and attain fictional immortality, a quartet of pre-med students at the University of Alabama found themselves with a mutual liking and much in common.

The four played together and worked together. They joined the same college fraternity. And in time they received their baccalaureate degrees at the same time, going their separate ways in pursuit of doctorates in medicine.



Drs. Bliss, Branyon and Murchison

The one who may be tagged the present-day D'Artagnan, appropriately wearing the French surname, LeMaistre, and known irreverently to his friends at the University as "Mickey," now bears the high-sounding title and heavy responsibility of "Chancellor for Health Affairs" for the whole University of Texas system.

The other three inseparables of undergraduate days chose separate colleges in which to earn the degrees that lead to a license to practice medicine.

Only Richard Frederic Bliss elected to remain at the University of Alabama, in the College of Medicine. Edgar Watterson Branyon, Jr., went to Columbia and Grover Cleveland Murchison, Jr., to Cornell. All born in the same year, all would have finished in the same year but for the fact that Dick Bliss interrupted his medical education with a tour of duty in the United States Marine Corps.

Today they live in three different towns, in two different congressional districts; two are in General Practice and one a Roentgenologist.

In the latter specialty is Dr. Ed Branyon, who returned to his native Anniston to marry his childhood sweetheart, Mary Leyden. Of their three children, the eldest, David, is a pre-med student at Emory. The younger children are Phil and Laura.

A native of Birmingham, Dick Bliss was married two years before he was graduated in medicine to Willie Nell Biggs. They established residence in Talladega in 1951, following his residency in South Highland Infirmary, Birmingham, and there are four children: Deborah Louise, Richard Frederic, Jr., Sarah Catherine, and William Ernest. Dr. Bliss's biography appears in Who's Who in the South and Southwest.

The third member of the pre-med trio returned to Montgomery, was married to Hettie Hopkins (also a childhood sweetheart known as "Tut"), and they have five children: Grover Richardson Murchison, who at the age of 21 already has his commercial flying license, a junior at Auburn; Cary, an Auburn sophomore, an accomplished and enthusiastic equestrienne; Mary, a freshman at Salem College in North Carolina; Hettie (nicknamed "Tutta," from which her Mother's nickname of "Tut" derived), now in the 10th grade at Jefferson Davis High School; and Agnes Marks Murchison, 12, in Cloverdale's 7th Grade.

And the three Alabama doctors, the in-

separables of pre-med days whom some imaginative person might have labeled Athos, Porthos and Aramis, after the three musketeers of the Dumas novel, are reunited this year in a common cause—the defense of medicine against its complete reshaping by political expediency.

They are all in ALAPAC:—

Dr. Murchison as 1969 chairman of the Board of Directors of this Alabama Medical Political Action Committee; Dr. Bliss as director for the 4th Congressional District; and Dr. Branyon, a recent recruit, whom Dr. Bliss plans to name to his district board.

Lehman Chair of Pediatrics

A chair in pediatrics, endowed by a substantial gift from Mrs. Herbert H. Lehman, in memory of her husband, has been established at the new Mount Sinai School of Medicine, New York, with Dr. Horace L. Hodes as chairman and the first Herbert H. Lehman Professor of Pediatrics. Members of the Lehman family have been associated with Mount Sinai since the 1870s.

FLYING DOCTORS MEET IN JUNE

More than 700 in some 250 private aircraft are expected to attend the 15th annual meeting and lecture series of the Flying Physicians Association, a five-day meeting to be held at Lake Placid Club, Essex County, N. Y., June 15-20. Dr. Robert L. Wick, Jr., of Columbus, Ohio, is program chairman. Top authorities in aviation safety and aerospace medicine will speak. And several doctor-pilots from Alabama are expected to attend.

3 CAUSES OF FIRE

The three causes of fire, suggests AMA's Timely Tip on Health and Safety, are men, women and children.

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PHYSICIAN PLACEMENT SERVICE IN ALABAMA

The Physician Placement Service of the Medical Association of the State of Alabama is designed to assist both physicians and communities. MASA members having knowledge of practice opportunities or wishing to relocate their own practices are urged to communicate with the Placement Service. For further information: write Mr. Emmett Wyatt, Executive Assistant, Medical Association of the State of Alabama, 19 South Jackson Street, Montgomery, Alabama 36104, or Telephone 263-6441.

Locations Wanted

General Practice—

Age 44, Medical College of Alabama, 1967, seeking associate practice in town of 12,000 plus population in central or south Alabama. LW-1

Age 56, Georgetown University 1938; seeking solo, group or associate practice, with general surgery. LW-2

Age 52; University of Chicago 1950; seeking group, industrial, institutional or student health position. LW-3

Age 31, Western Reserve, 1964; seeking group, associate or institutional practice. LW-4

Age 38; University of Oklahoma, 1955; seeking associate, institutional or industrial practice; in town of 10,000 plus population; interest in surgery. LW-5

Age 28; Medical College of Alabama 1966; seeking practice in town of less than 14,000 population to fulfill scholarship requirements. LW-6

Age 28; University of Tennessee, 1965. LW-7

Age 27, Medical College of South Carolina, 1966; seeking location in Gadsden area or in southern part of state in town of 5-7,000 population; available July 1, 1971. LW-7/1

Age 38; Medical College of Alabama, 1957; seeking location in south Alabama. LW-7/2

Age 60, University of Arkansas 1932, seeking location for general or industrial practice. Available May 1969. LW-7/3

Internal Medicine—

Age 36, Medical College of Alabama, 1963; seeking solo, group, or associate practice. LW-8

Age 34; Hahnemann Medical College 1959; Board eligible, National Board; seeking solo, group, or associate practice. Available immediately. LW-11

Age 35; University of Tennessee 1958; Board certified; seeking group, industrial or institutional practice. LW-12

Age 37, Duke University, 1956; Board certified, seeking group, associate, or institutional practice. LW-13

Neurology—

Age 32, Medical College of Georgia, 1964, seeking assistant or associate, or institutional practice. LW-14

Age 31; Harvard 1962; Board eligible; National Board; seeking solo, group or associate practice. Available July 1969. LW-15

Age 30; Medical College of Alabama 1962; Board eligible; National Board; seeking solo, group, associate or institutional practice. Available January 1969. LW-16

Age 29, Indiana Univ., 1964; Board eligible; seeking assistant or associate practice in city of over 100,000 population; available July 1, 1969. LW-17/1

Obstetrics-Gynecology—

Age 35, Vanderbilt University, 1950. Board eligible. LW-18

Age 49, University of Nebraska, 1943; Board certified, seeking group or institutional practice. LW-19

Age 34, Medical College of Virginia, 1961, Board eligible, seeking group or associate practice. LW-20

Age 33; University of Illinois, 1964; seeking associate practice. LW-21

Ophthalmology—

Age 33; St. Louis University, 1962; seeking solo, or associate practice; available July 1, 1969. LW-21/1

Otolaryngology—

Age 32, University of Pennsylvania 1962, seeking associate practice. Available April 1970. LW-21/2

Age 35, University of Miami 1959, seeking location in city of 150,000 plus population. Available August 1970. LW-21/3

Psychiatry—

Age 52, Chicago Medical School 1939; Board eligible; seeking group or institutional practice, preferably near Gulf Coast. LW-22

Surgery—

Age 30; Duke University School of Medicine, 1964; seeking location in larger cities. LW-26

Age 33; University of Missouri, 1961; seeking group or associate practice. Available January 1969. LW-27

Age 38; Emory University, 1956; Board eligible, seeking group, associate, or institutional practice. LW-28

Age 37; Faculty of Medicine, Manitoba, 1957; Board certified; seeking associate or institutional practice. LW-29

Age 34; University of Santo Tomas, 1961; Board eligible, seeking group or associate practice. LW-30

Age 35; University of Santo Tomas, 1956; Board eligible, seeking solo, group or industrial or associate or institutional practice. LW-31

Locations Wanted

(Continued)

Age 36, Indiana University 1961; Board eligible; seeking practice in city of 100,000 plus population. Available July 1969. LW-31/1

Age 37, University of Paris 1961; seeking group or institutional practice in city of 80,000 plus population. Available July 1969. LW-31/2

Urology—

Age 30; Louisiana State University, 1963; Board eligible, seeking associate, or group practice. LW-32

Age 31, Chicago Medical School 1963, seeking associate practice in Montgomery. Available July 1970. LW-32/1

Physicians Wanted

Special Openings—

Specialist in the following fields: Internal Medicine, Pediatrics, Obstetrics-Gynecology and General Practitioners. 58-bed fully accredited general hospital with 91-bed addition recently completed. Modern new office space available. PW-20

Pediatrician, Internist, and ENT specialist to join a well-established group practice in a community of 40,000 in East Alabama. The community has a 125-bed accredited hospital, 32-bed extended care facility. Good transportation on interstate with quick access to metropolitan area. Will pay travel expense for interview. PW-20-1

Opportunity for ENT, Internal Medicine, and Orthopedic Surgery practitioners to join partnership at clinic located in city of 38,000 population in trade area of 150,000 population in northeast Alabama. PW-20/2

Position for full-time industrial practice at textile plant with 2,400 employees at Decatur, Alabama. PW-20/3

Internists, Board-certified or eligible. One needed now and another in 1 or 2 years. For early partnership with internist in south Alabama city of 40,000 plus population. New office building adjacent to 181-bed hospital. Practice largely hospital in-patient and Cardiology. PW-21

Opportunity for physician interested in joining a progressive public health tuberculosis control program working in Birmingham, Jefferson County. Provide outpatient medical services and some administrative duties. Fringe benefits and salary open. PW-22

Obstetrician-Gynecologist—

Excellent opportunity for a trained Ob-Gyn man who would join a three-man partnership practice in city of 30,000 population located in southwest Alabama. Salary is proposed for the first 12 months, a limited partnership to begin at the end of twelve months, and full partnership to begin at the end of 24 months. PW-25

General Practitioners—

Opportunity in town of 4,000 population in trade area of 50,000 population, located within 100 miles of two metropolitan areas in south Alabama. Industrial and farming area. 44-bed hospital. Office space and equipment available in new building with another physician. Several churches, schools, and service clubs. PW-1

For community of 1,500 population located in south Alabama near city of 12,000 population. Hospitals located within 25 miles. Office space and equipment available. Farming, cattle and textile industries in the area. Several churches and school. Civic clubs and golf courses. PW-1-1

For town of 10,000 population in county of 40,000 population located in scenic mountainous section of Northeast Alabama. Office space and equipment available. Hill-Burton hospital-nursing home. Expanding industries in top agricultural area. PW-1-2

For community of 2,000 population, plus large trade area, located in Southeast Alabama. Modern clinic, fully equipped. PW-1-3

Opportunity in port town of 1,000 plus population in population center of 10,000 located in Southeast Alabama. Clinic available. Hospital located less than 20 miles away. Recreational advantages for water sports. Expanding industrial and farming area. Churches and schools. PW-1-4

For town of approximately 1,000 population in Northwest Alabama, near Tennessee Valley waterways. New 15-bed clinic available. Centrally located near metropolitan areas. Extensive industrial developments. PW-1-5

For town of 12,500 population in trade area of 50,000 located in South Alabama. Nearest large city with population of 145,000 is 80 miles away. Two hospitals with 140 beds. Numerous small industries. Several churches and schools. Recreational activities include water sports and golf course. PW-1-6

General Practitioner to join partnership in town of 3,000 population, plus trade area of 20,000 population in northwest Alabama. Modern office building with six examining rooms. Full partnership at beginning of third year. New 30-bed Hill-Burton hospital. Salary open. PW-1/7

Opportunity in community of 3,000 population with over 8,000 population in trade area, near metropolitan area in northwest Alabama. Clinic and office equipment available. New 400-bed hospital and older hospital, and several nursing homes. PW-1/8

For town of 2,000 population in trade area of 7,000 population located in west Alabama. Physician recently died. Nearest city is 30 miles away. Medical facilities include Hill-Burton hospital and nursing home. Churches, schools, civic clubs, and recreational advantages. PW-1/9

For town of 1,800 population located in southeast Alabama in a population center of 10,000 population. PW-1/10

(Continued on Page 998)

Physicians Wanted

(Continued from Page 997)

Opportunity for group practice in town of 10,000 population in north Alabama. PW-2

Physician wanted to join 39 year old Medical College of Alabama graduate in a well established general practice in West Central Alabama town. Salary initially followed soon by full partnership. PW-3

Opportunity in community of 5,000 population in trade area of 30,000 population located in northeast Alabama where at present time there are only two active full time general practitioners. Modern offices or clinic facilities available. 48-bed accredited hospital and 52-bed skilled nursing home adjoining the hospital. Cities of approximately 75,000 population located within 25 miles distance. Agricultural and expanding industrial area. Numerous churches and schools. Country club and golf course being developed and water sports and outdoor activities offer recreational advantages. PW-4

Physician wanted to join well established partnership in Northwest Alabama city of 15,000 population. Two accredited hospitals, junior college, schools, churches, recreational activities. No obstetrics or surgery. New office building. PW-7

For city of approximately 15,000 population in north Alabama, with trade area of approximately 45,000 population. Hospital with over 100 beds, and expansion planned for next year. Nursing homes in the area. Industrial growth and agricultural region. Several churches and schools. Golf course, civic and fraternal organizations. PW-8

For partnership practice in clinic in town of 2,000 population in area of 10,000 population located in north-central Alabama. 40-bed hospital. PW-9

For assistant or associate in clinic located in town of 10,000 population located in northeast Alabama. 65-bed Hill-Burton hospital. PW-10

For associate practice in city of 6,000 population in area of over 10,000 population located in East-central Alabama. PW-11

For solo practice in county clinic located in East-central Alabama. Office, equipment and housing available. 70-bed Hill-Burton Hospital and 22-bed nursing home. PW-12

For town in southwest Alabama, approximately 1,000 population in trade area of approximately 5,000 population, within 60 miles of large city of 35,000. Nearest hospital is located 18 miles away. Arrangements available for office space. Small industries and agriculture. Civic clubs and golf course nearby. Churches and school. PW-13

For town of 1,000 plus population in west-central Alabama in trade area of 20,000. Clinic available. Nearest city of approximately 70,000 population is located a distance of 17 miles. Farming, cattle, timber, and manufacturing plants are principal resources of the area. Churches, schools, and recreational advantages. PW-15

Opportunity for general practitioner to join a five-man group, practicing as a partnership. Each man in the group is either specialized or semi-specialized. The practice is physically located within a 70-bed hospital. Willing to pay qualified person $36,000 for the first year, with possible partnership status in one year. Would consider a physician for locum tenens for three to six months at $2,000 per month. PW-16

For town of 3,600 population in trade area of 5,000-7,000 within 100 miles of two large cities and the Gulf Coast. 50-bed hospital located in the town. Office space available. Agricultural and expanding industrial area. Several churches and two schools. Recreational activities in the town as well as nearby—golf course, hunting and fishing. PW-17

Unusual opportunity for two general practitioners with military obligations satisfied at a modern fifty bed facility located 15 minutes drive from largest metropolitan center in north-central Alabama. Construction of a new two-story office building is scheduled to begin soon. PW-18

Opportunity in city of 5,000 population located in Northeast Alabama in trade area of approximately 10,000 population. Office space available. One physician died recently. Hospital and nursing home in the city. PW-19

The Sword was Turned Upon the Commissioner

E. Jackson Boggs, LL. B.

Once upon a time, Congress created a sword. The sword is found in Section 7701 (a) of the Internal Revenue Code of 1954, which provides in part that "the term 'corporation' includes associations . . .". The sword was actually created a long time ago with enactment of the Revenue Act of 1894. It was then retained in the Revenue Act of 1918, and again presented itself in its same mighty form in the Internal Revenue Codes of 1939 and 1954.

First to seize the sword was the commissioner of Internal Revenue, and he found it to be a powerful weapon. How many times he gained a victory short of court battle, we do not know. We do know that as early as the middle 1930's some taxpayers fought back and shielded their way into the courts, but their shields were no match for the mighty sword[1]. In one case the commissioner used the sword against three practicing physicians who had formed a trust called "The Pelton Clinic." The court held, contrary to the contention of the physicians, that the clinic more nearly resembled a corporation than a trust and therefore was to be taxed as a corporation. On some occasions the shields thrown up by the taxpayers robbed the sword of victory, but the occasions were few in number.[2]

In each of the cases, the commissioner said to his victims or intended victims, "Even though you are not a corporation under state law, the sword which Congress created gives me the right under the facts of your case to tax you as a corporation and therefore so shall you be taxed." The taxpayer in each case cried, "No, I am not incorporated under state law, do not want to be, and should not be taxed as a corporation." As previously mentioned, such cries were usually in vain.

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Sword Turned

Then, one day a strange thing happened. Certain professional persons, who could not incorporate under state law, realized that they might be able to make good use of the same sword theretofore used so successfully by the commissioner. The taxpayers, Dr. Kintner and his associates, determined in 1948 that under the facts of their case and the circumstances of the times they would like to be taxed as a corporation.

Why would one desire this? There are many nontax reasons, but among those relating to federal taxes are that the professional man as a corporate employee may participate, along with the other employees, in tax-deferred retirement, profit-sharing or pension plans, in deductible group term life insurance and group medical coverage, in limited tax-free "sick pay" plans and in plans whereby their estates or widows receive limited tax-free death benefits. It should also be noted that prior to 1938 the income tax law did not provide for tax-deferred retirement, profit-sharing and pension plans, and it was not until 1942 that the individual graduated rates similar to those in effect today were enacted into law. To be taxed as a corporation after 1938, or certainly after 1942, thus could become advantageous.

Kintner, therefore, seized the sword and turned it upon the commissioner, saying to him, "With this sword and under the facts of our operation, we are to be taxed as a corporation." Astounded that a taxpayer would attempt to use the sword which previously had been used so successfully by him, the commissioner fought back vigorously. But, he found that *his* shield was no better than the shields which he, the commissioner, had previously battered and beaten to oblivion against the taxpayers. Thus, Kintner won a

smashing victory! The courts decreed and held that he and his associates were to be taxed as a corporation. This is what they wanted; not what the commissioner wanted for them.[3]

Sword Little Used

Strangely enough, during the period from 1954, when Kintner won his victory in the appellate court, until 1967, only two professional groups used the sword to battle their way into the courts, although both groups were successful.[4] One principal reason for the court inactivity from 1954 to 1967, in spite of the fact that the sword was having unilateral success, probably relates to the tremendously successful psychological warfare tactics employed by the commissioner. The tactics, in retrospect, appear to have been designed only as dilatory measures, but they were obviously quite successful to that end.

Thus, in late 1959, when many taxpayers probably were ready to do battle with the mighty sword, the commissioner in effect announced "Wait! I am going to publish some new regulations which will spell out the use of the sword in detail."[5] Wanting to avoid war in the courts if possible, many taxpayers waited for the regulations, which they thought might "show them the way." To the extent that professional men were waiting for guidance from their government, they waited in vain. For approximately one year later, on Nov. 15, 1960, the commissioner published the anxiously waited-for regulations.[6] They were complicated and filled with legal jargon, but in essence said one thing—professional men cannot and must not be allowed to win with the sword.

The commissioner's 1960 regulations noted that the Internal Revenue Code establishes the tests or standards for determining corporate status. But, said the regulations, obviously realizing that at that time professional men were not allowed to incorporate under state law, local law governs in determining if the tests are met. Prior to that time the regulations under Section 7701 had stated that "local law is of no importance in this connection." The about-face by the commissioner undoubtedly seemed by him at the time a good defensive measure, but in fact, it merely caused the states to soon implement the professional taxpayer in his use of the already powerful sword (if in fact it did not pave the way for the creation of a new sword). Thus, many states passed laws which said that professional men could in fact incorporate their professional businesses under state law. If local law controlled, the commissioner would surely go down to defeat in these states. The commissioner was not about to concede defeat, however, and on May 8, 1963 he announced that new regulations concerning the new state professional service corporation laws would be issued.[7] Not so many taxpayers were lulled into nonaction this time, but the tactics of the commissioner continued to work as a dilatory measure, at least against some.

Sword More Popular

On Feb. 2, 1965, the new set of regulations in the form of basic amendments to the 1960 regulations were finally issued. These new regulations in effect simply said again that the sword would not work when used by professional persons, regardless of the fact of incorporation under state law as a "Professional Service Corporation." By this time many taxpayers were ready to take the mighty sword, as implemented in some cases by the new state laws, into court if necessary. The commissioner was still holding up his rusty and battered shield, but he obviously felt himself in trouble. Undoubtedly, he reasoned, those who had already taken up the sword for 1964 and prior years were not going to give up those years on the basis of the 1965 regulations.

The commissioner decided there was only one thing left to do at that point—concede all professional service corporation cases for the years 1961 through 1964, but come out fighting for all years thereafter. Thus, along

(Continued on Page 1002)

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(Continued from Page 1000)

with the 1965 regulations, the commissioner made his famous announcement creating an amnesty for the period indicated during which time he would not go into battle.[8] However, through his tough new regulations, he warned against future use of the sword by professional persons. "The sword cannot win! All professional taxpayers must throw down their swords and give up! If not, I, the commissioner, will fight you to the bitter end!"

Again, the psychological warfare probably worked on some but not all. In fact, four groups of professional taxpayers have recently slashed their way to impressive victories in the courts.[9] Thus, it is seen that since Kintner first turned the sword upon the commissioner approximately 20 years ago, those taxpayers who were brave enough to do battle in the courts have been successful. The sword is available for use by all, which means, of course, that it is still available for use by the commissioner when he chooses to use it.[10]

To Remain Unblemished

For professional men who remain self-employed and desire not to be taxed as a corporation, certainly it should be an easy task to avoid having the sword used against them. In fact, it is very doubtful that the commissioner will ever again attempt to use the sword against professional persons, and he is perhaps now sorry about his success against the practicing physicians operating as "The Pelton Clinic" in 1936. As to those who desire to remain self-employed, Congress has attempted some measure of tax equality between them and corporate employees insofar as retirement plans are concerned by the enactment of the Self-Employed Retirement Act, also known as the "Keogh Act" or "H. R. 10." However, retirement plans for self-employed persons offer less advantages in that (1) a larger deductible contribution is allowed under the corporate plan (under H. R. 10 the limit is $2,500 for owners or partners); (2) more flexibility is allowed with regard to coverage by classes under the corporate plan; (3) the vesting schedule is more liberal under the corporate plan; (4) integration with social security is available only under the corporate plan; (5) lump sum distribution produces capital gain under corporate plan as opposed to ordinary income under self-employed plan; (6) the use of trustees is more liberal under the corporate plan, and (7) death proceeds are estate tax-free under the corporate plan and taxable under the self-employed plan.

It appears that in spite of the commissioner's attempt to discriminate against professional persons and deny to them the use of the sword to obtain taxation as a corporation, Congress in creating the sword intended to discriminate against no one, not the commissioner, not taxpayers in general, and certainly not one particular taxpayer as opposed to another. As stated by the court in one of the recent cases,[11] "the discrimination (against professional persons) perpetuated in the (1965) regulation is not supported by the statute, judicial precedent or sound tax policy." And, so it should be, for as long as there is no discrimination in its use, the sword will remain unblemished, as will the Congress who created it and the courts who decide the outcomes of the battles.

References

1. Cases won by the commissioner during this period include Morrissey v. Commissioner, 296 U. S. 344 (1935); Helvering v. Coleman-Gilbert Associates, 296 U. S. 369 (1935); Swanson v. Commissioner, 296 U. S. 362 (1935); Thrash Lease Trust v. Commissioner, 99 F. 2d 925 (9th Cir. 1938), Cert. den., 306 U. S. 654; and Pelton v. Commissioner, 82 F. 2d 473 (7th Cir. 1936).

2. Cases lost by the commissioner include T. A. Johnson, 38 B. T. A. 1199 (1938), appeal to 5th Cir. dismissed; and Commissioner v. Gerstle, 95 F. 2d 587 (9th Cir. 1938).

3. U. S. v. Kintner, 216 F. 2d 418 (9th Cir. 1954), aff'm. 107 F. Supp. 976 (D. C. Mont., 1952).

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4. Galt v. United States, 175 F. Supp. 361 (D. C. Tex. 1959) and Foreman v. United States, 232 F. Supp. 134 (D. C. S. D. Fla. 1964).

5. Announcement on Dec. 23, 1959, 24 Fed. Reg. 10450.

6. 1960 Treas. Regs. 301.7701.

7. T. I. R. No. 471, I. R. B. 1963-21, p. 42.

8. Rev. Proc. 65-27, 1965-2, C. B. 1017.

9. Empey v. United States, 272 F. Supp. 851 (D. C. Colo. 1967), appeal docketed, No. 9814, 10th Cir. Dec. 18, 1967, O'Neill v. United States, 281 F. Supp. 359 (N. D. Ohio, 1968), Kurzner v. United States, ___F. Supp. ___ 68-2 USTC 9514 (D. C. S. D. Fla., 1968) and Holder v. United States, ____F. Supp. ____ 68-2 USTC 9504 (D. C. N. D. Ga., 1968). See also Drs. Hill & Thomas Co. v. U. S., 392 F. 2d 205 (6th Cir. 1968) where the court dismissed the corporations refund suit for the year 1965 as being moot because the commissioner had already refunded all of the taxes paid by the corporation (apparently since the commissioner did not recognize the corporation as a separate tax entity under the 1965 regulations).

10. See for example, the recent case of National Savings & Trust Co. v. U. S., ____F. Supp. ____ 68-1 USTC 9371 (D. C. D. C., 1968), where the commissioner successfully used the sword in contending that a real estate trust, although unincorporated, should be taxed as a corporation because it had more corporate characteristics than those of a trust.

11. O'Neill v. United States, supra.

Mr. Boggs is a member of the Tampa law firm of Fowler, White, Collins, Gillen, Humkey and Trenam.



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A breakthrough in the continuing war on "German measles" and the dread rubella-associated defects that mark the child born of an infected mother is being hailed widely in medical circles, and one of the three doctors hailed as key figures in the development of rubella vaccine was a featured lecturer in the scientific session at last year's annual meeting.

He is Dr. Saul Krugman of New York, professor and chairman, Department of Pediatrics, New York University School of Medicine.

His subject at the Birmingham meeting, appropriately, was "Current Live Virus Vaccines."

Reports of progress in the rubella vaccine development that may save uncounted thousands of the future's children from crippling physical and mental defects were made at an international conference on the subject held in Bethesda, Md., in February, and later reviewed in the Journal of the American Medical Association (JAMA).

Meantime, anticipating approval of the vaccine later this year, the Public Health Service is preparing to inoculate 20 million children in mass campaigns during the first three months of 1970. The Department of Health, Education and Welfare has asked Congress for $25.6 million to finance next year's inoculation program. The work would be supervised and administered by state health departments.

AMA's 1969 Convention Features Viewing, Listening

An abundance of valuable information will be presented in a variety of interesting ways to those attending the American Medical Association's 1969 Annual Convention in New York City.

Some information will be available to visitors in the comfort of their convention hotels or motels. This will be through the special televising of convention news, interviews, panels, and scientific presentations.

Such TV programming, a highlight of AMA Annual and Clinical Conventions in recent years, will be available from 5 p. m. to midnight Sunday, July 13; from 7 a. m. to 9 a. m. and from 5 p. m. to midnight Monday through Wednesday, July 14 through 16; and from 7 a. m. to 9 a. m. Thursday, July 17.

Much of the scientific activity of the July 13 through 17 Annual Convention will be in the Coliseum and New York Hilton Hotel. The House of Delegates will meet at the Americana Hotel.

In addition to papers and lectures which will be presented in the Coliseum and New York Hilton, there will be exhibits, color closed circuit television, and medical motion pictures.

Some 250 to 300 scientific exhibits are expected at the Coliseum, including special ones on arthritis, pulmonary function, fresh tissue pathology, fractures, resuscitation, and laboratory medicine.

Prominent Montgomery Doctor, Civic Leader and Clubman Dies

Haywood Sommerville Bartlett, M. D., past president of the Montgomery County Medical Society, founder of Professional Center Hospital, civic leader, clubman, and member of a pioneer Montgomery family, is dead just short of his 64th birthday. He was born June 6, 1905.



Dr. Bartlett

A specialist in Obstetrics and Gynecology, Dr. Bartlett also took an active part in community affairs, a past president of the Lions Club, a past president of its Blue-Gray Association which sponsors the annual football game played here on the last Saturday of each December. He served in the Medical Corps, attached to the Army Air Corps, in World War II. He was a Mason, and a Shriner, a Fellow in the International College of Surgeons, a member of AMA and of the Southeastern Surgical Association.

He was a founding member and at the time of his death president of the Krewe of Athenians, one of Montgomery's more spectacular mystic societies. He was also a member of the Society of Pioneers of Montgomery, meaning that members of his family had been residents of the Alabama capital city for more than 100 years.

His hobbies were soil-less agriculture, flowers and fishing, and a letter-to-the-editor published in the week of his death called him "one of Montgomery's most beloved doctors," adding that "his death was a great shock to Montgomery and he will be missed by many people in all walks of life. . . .

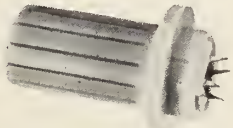
"Dr. Bartlett loved people and his greatest joy was being able to help others. At one time he told me the most wonderful feeling in the world is to see a strong, healthy person walk out of his office and know he had a small part in helping to make him that way. He often said that the greatest drawback he had in practicing medicine was getting personally involved in each case. . . .

"It is with deep sadness and a heavy heart that Montgomery says farewell to Dr. Haywood Bartlett. His memory will live in the hearts of the people of Montgomery for many generations."

Dr. Bartlett is survived by his widow, the former Elmore Bellingrath; a son, Dr. Haywood Bellingrath Bartlett, Pike Road; a daughter, Mrs. James T. Inscoe.

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Electrocardiography and Carbohydrate Metabolism: I. P-Wave Length (Lead I) in Presumably Healthy Young Men

by

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and

W. M. Ringsdorf, Jr., D. M. D., M. S.**

Introduction

There is increasing awareness of relationships between cardiovascular disease and carbohydrate metabolism.[1-10] Within this area, there are several reports which note interesting correlations between electrocardiography and carbohydrate metabolism.[11-15]

This paper, the first in a series, correlates a segment of the electrocardiographic pattern in presumably healthy young men with their postprandial blood glucose levels. Specifically, an attempt will be made to answer the following three questions:

1. How reproducible is the measurement of P-wave length in Lead I?
2. How constant is P-wave length (Lead I) recorded four days apart in a group of presumably healthy young men consuming a regular diet?
3. Is there any relationship between the P-wave length (Lead I) and blood glucose (recorded four days apart) in healthy young men subsisting on a regular dietary regime?

Method of Investigation

Thirty-eight presumably healthy junior dental students participated in this experiment. On Monday of a week, routine electrocardiography (Leads I-III) was performed at about 10:00 A. M. In addition, a three-hour postprandial blood glucose (Somogyi-Nelson method)[16-17] determination was made. On Friday of the same week at 10:00 A. M. electrocardiograms and blood glucose assays were repeated.

The electrocardiographic patterns were read under a dissecting microscope with a magnification of 60X.[18] Each measurement was repeated (to insure accuracy) by the same examiner with no knowledge as to the student's name, lead, or visit number.

Results

Question One: An attempt was first made to establish the constancy of the measuring technique. Table 1 lists the first and second P-wave length readings at the initial and

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final visits. Of the seventy-six duplicate measurements, only ten were different (Table 2). Of these ten, seven varied by .01 seconds and three by .02 seconds. The significant ($P < 0.01$) coefficient of correlation (+0.960949) attests to the reproducibility of the measuring technique. *Hence, in answer to the first question, it is fair to state that a high degree of accuracy was achieved in measuring the P-wave length in Lead I.*

Question Two: How constant is the P-wave length (Lead I) during a four-day interval in healthy young men subsisting on a regular diet? Table 1 lists the mean initial and final P-wave lengths. The coefficient of correlation proved to be +0.259712 and its lack of significance is underscored by a $P < 0.05$. *Apparently, in answer to question two, healthy young men subsisting on a regular diet did not show a constant electrocardiogram as expressed in Lead I P-wave length.*

Question Three: It is abundantly clear that the P-wave length in Lead I fluctuated from day to day. Although some of the changes may have been due to the method of measurement, undoubtedly other factors were also operative. The question now to be answered is whether there is any relationship between the P-wave length in Lead I and carbohydrate metabolism. To answer this question, one may examine the blood glucose levels recorded on Monday and Friday in these students.

Table 3 summarizes the nonfasting blood glucose determinations at these two visits. The initial and final values are 80.4±9.3 and 81.9±10.9 mg. per cent, respectively. The lack of statistical significance is underscored by a coefficient of correlation of +0.253 and a $P > 0.05$.

Figure 1 describes the initial-final differences in P-wave length on the abscissa and those for blood glucose on the ordinate. The correlation coefficient of 0.139910 with a $P > 0.05$ suggests that fluctuations in the electrocardiographic pattern were not in parallel with the direction of variation in blood glucose. Figure 2 portrays the changes in P-

Table 1

frequency distribution of P-wave length

case number	first visit			second visit		
	first reading	second reading	mean	first reading	second reading	mean
03286	0.08	0.07	0.075	0.09	0.08	0.085
03287	0.06	0.06	0.060	0.04	0.04	0.040
03290	0.08	0.08	0.080	0.06	0.07	0.065
03296	0.04	0.04	0.040	0.06	0.06	0.060
03298	0.08	0.08	0.080	0.08	0.08	0.080
03300	0.07	0.06	0.065	0.07	0.07	0.070
03301	0.07	0.07	0.070	0.11	0.11	0.110
03304	0.06	0.06	0.060	0.06	0.06	0.060
03305	0.08	0.08	0.080	0.08	0.08	0.080
03306	0.04	0.04	0.040	0.05	0.05	0.050
03307	0.12	0.11	0.115	0.08	0.08	0.080
03308	0.08	0.08	0.080	0.10	0.10	0.100
03309	0.04	0.04	0.040	0.10	0.10	0.100
03319	0.07	0.07	0.070	0.08	0.08	0.080
03321	0.08	0.08	0.080	0.10	0.10	0.100
03323	0.06	0.06	0.060	0.12	0.12	0.120
13158	0.08	0.08	0.080	0.12	0.11	0.115
13160	0.12	0.12	0.120	0.08	0.08	0.080
13163	0.12	0.12	0.120	0.10	0.10	0.100
13165	0.08	0.08	0.080	0.08	0.08	0.080
13167	0.08	0.08	0.080	0.08	0.08	0.080
13169	0.09	0.10	0.095	0.07	0.07	0.070
13170	0.08	0.08	0.080	0.06	0.06	0.060
13174	0.08	0.08	0.080	0.08	0.08	0.080
13176	0.08	0.08	0.080	0.08	0.08	0.080
13178	0.04	0.04	0.040	0.06	0.06	0.060
13179	0.08	0.08	0.080	0.06	0.08	0.070
13182	0.08	0.06	0.070	0.08	0.08	0.080
13184	0.08	0.08	0.080	0.08	0.08	0.080
13186	0.08	0.08	0.080	0.08	0.08	0.080
13191	0.08	0.08	0.080	0.08	0.08	0.080
13193	0.08	0.10	0.090	0.08	0.08	0.080
13194	0.08	0.08	0.080	0.10	0.10	0.100
13197	0.08	0.08	0.080	0.08	0.08	0.080
13198	0.08	0.08	0.080	0.08	0.08	0.080
13199	0.08	0.08	0.080	0.08	0.08	0.080
13203	0.08	0.08	0.080	0.08	0.08	0.080
13204	0.08	0.08	0.080	0.10	0.10	0.100

Table 2

frequency distribution of P-wave length difference in Lead I in duplicate measurements

difference (seconds)	number of subjects	percentage of subjects
0.00	66	86.8
0.01	7	9.2
0.02	3	3.9
Total	76	100.0*

*approximate

Table 3

initial and final P wave lengths and blood glucose levels

case number	P wave length initial	P wave length final	P wave length differences	blood glucose initial	blood glucose final	blood glucose differences
03321	0.080	0.100	+0.020	63	63	0
13191	0.080	0.080	0.000	85	85	0
03300	0.065	0.070	+0.005	92	90	− 2
03304	0.060	0.060	0.000	80	78	− 2
03307	0.115	0.080	−0.035	80	82	+ 2
13158	0.080	0.115	+0.035	85	83	− 2
13174	0.080	0.080	0.000	83	85	+ 2
13193	0.090	0.080	−0.010	92	90	− 2
13204	0.080	0.100	+0.020	80	82	+ 2
03306	0.040	0.050	+0.010	83	80	− 3
13163	0.120	0.100	−0.020	80	83	+ 3
13169	0.095	0.070	−0.025	87	84	− 3
13170	0.080	0.060	−0.020	81	84	+ 3
13194	0.080	0.100	+0.020	80	83	+ 3
13176	0.080	0.080	0.000	70	74	+ 4
03286	0.075	0.085	+0.010	75	70	− 5
13184	0.080	0.080	0.000	83	78	− 5
13198	0.080	0.080	0.000	85	90	+ 5
13203	0.080	0.080	0.000	87	82	− 5
03298	0.080	0.080	0.000	80	73	− 7
13167	0.080	0.080	0.000	83	90	+ 7
13178	0.040	0.060	+0.020	92	85	− 7
13186	0.080	0.080	0.000	85	92	+ 7
13197	0.080	0.080	0.000	85	78	− 7
13182	0.070	0.080	+0.010	75	83	+ 8
13199	0.080	0.080	0.000	92	100	+ 8
03308	0.080	0.100	+0.020	75	84	+ 9
03319	0.070	0.080	+0.010	73	83	+10
13179	0.080	0.070	−0.010	95	105	+10
13165	0.080	0.080	0.000	80	91	+11
13160	0.120	0.080	−0.040	70	83	+13
03290	0.080	0.065	−0.015	77	63	−14
03301	0.070	0.110	+0.040	57	71	+14
03323	0.060	0.120	+0.060	95	80	−15
03287	0.060	0.040	−0.020	65	80	+15
03296	0.040	0.060	+0.020	76	57	−19
03305	0.080	0.080	0.000	91	60	−31
03309	0.040	0.100	+0.060	60	110	+50

wave length on the abscissa and the change in blood glucose between initial and final visits on the ordinate. No attention was accorded whether the fluctuations were positive (up) or negative (down). Under these conditions, there is a statistically significant relationship ($r=0.431651$, $P<0.01$). *Thus, in response to the last question, it would appear that electrocardiographic fluctuations parallel blood glucose changes. In other words, when P-wave length shortens or lengthens, blood glucose rises or decreases.*



Figure 1. The relationship of differences in blood glucose (abscissa) and P wave length in Lead I (ordinate). There is no statistically significant relationship ($r = +0.139910$, $P>0.05$) when the pattern is viewed in the light of the direction of change.

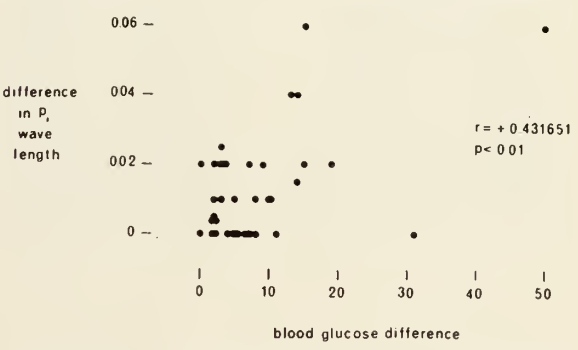


Figure 2. The relationship of differences in blood glucose (abscissa) and P wave length in Lead I (ordinate). There is a statistically significant correlation ($r = +0.431651$, $P<0.01$) when the pattern is viewed without regard to direction of change.

Discussion

Within the limits of this study, it appears that the inconstancy of P_1 length parallels inconstancy in postprandial blood glucose. However, the orderliness ends here. One does not find that the *direction* of electrocardiographic change correlates with the *direction* of blood glucose change.

Rene Dubos,[19] in his writings about Claude Bernard and homeostasis, made the following relevant statement:

He (Claude Bernard) emphasized that at all levels of biological organization, in

plants as well as in animals, survival and fitness are conditioned by the ability of the organism to resist the impact of the outside world and maintain constant *within narrow limits* (italics added) the physicochemical characteristics of its internal environment.

On the assumption that the steady state is indeed very steady, the evidence here suggests that individuals with the most stable blood glucose also have the most stable P_1 length.

Summary

1. Thirty-eight presumably healthy junior dental students participated in an experiment in which the length of the P-wave in Lead I and blood glucose by the Somogyi-Nelson method were determined at 10:00 A. M. on Monday and Friday of the same week.

2. The evidence suggests that the measurement of P_1 length is highly reproducible. Also, the data suggest that, for the group, P wave length is quite inconstant from Monday to Friday.

3. It is reasonable to assume from the information available in this report that the individuals with the most constant blood glucose also show the most constant electrocardiographic pattern.

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Albert Gallatin Mabry[§]

by

Emmett B. Carmichael*

The subject of this biographical sketch was the individual who conceived the idea of organizing the physicians of the State of Alabama into a state wide association. He was present at its birth in 1847 in Mobile, and at its rebirth after the Civil War in 1868 in Selma.

Albert Gallatin Mabry was born on a farm near the town of Jerusalem, Southampton County, Virginia on September 7, 1810. His father, Richard Mabry, was a farmer in Southampton County and was of good standing in the community in which he lived. Richard's second marriage was to Polly Braxton and they had two children, Albert Gallatin and Robert. Richard died while the children were young and his widow married again. It seems that the stepfather did not prosper, so Albert was taught at an early age the habits of self-reliance.

At the age of 16 years, Albert went to Jerusalem and engaged in business. After a few years, he became discontented and his friends advised him to study medicine. Dr. William Spark was one of those who encouraged him to desert the business world for the medical profession. As a result, he read medicine with Dr. Spark and their friendship continued until Dr. Spark's death.

Albert enrolled in the Medical Department, University of Pennsylvania, in October 1835. The rules and regulations for conferring the degree of Doctor of Medicine included the following:

1. Every candidate for the degree must have attained the age of twenty-one years.



Albert Gallatin Mabry

2. He must have studied medicine for three years and during that time must have been a private pupil for at least two years of a respectable practitioner of medicine.

3. The candidate must have attended two complete courses of lectures.

4. He must have attended one course of Clinical Instruction in the Philadelphia Hospital or the Pennsylvania Hospital.

5. Each candidate must deliver a thesis in his own handwriting. General bad spelling or general inattention to the rules of grammar precludes a candidate from examination for a degree.

Albert Gallatin Mabry received the M. D. degree in March, 1837 and 165 other students graduated with him. Albert's senior thesis was on the "Use of Arctium Lappa in the Treatment of Scrofula." He returned to his

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county and began the practice of medicine in Jerusalem.

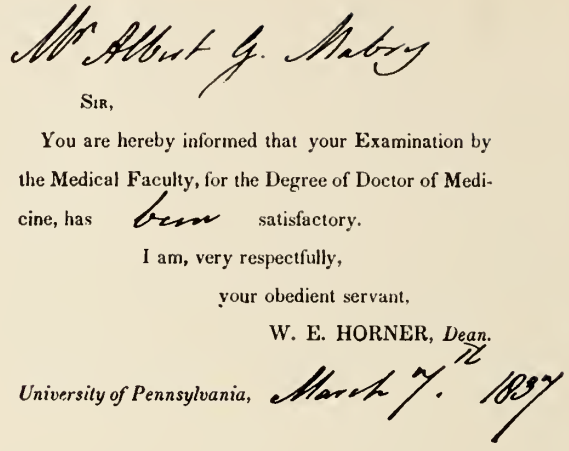
In the meantime his brother, Robert and his half sister, Susan, who had married James Lundy, had emigrated to Harris County, Georgia. About 1840 Dr. Albert Gallatin Mabry also moved to Harris County, Georgia, and opened his office in Whitesville, Georgia. After about three years, he moved to Selma, Alabama, where he became one of the leaders in the medical profession. On February 6, 1843, he presented his diploma to the local medical society and was duly licensed under the law of Alabama to practice medicine and surgery. Soon after he opened his office, he formed a partnership with Dr. Drewry Fair, a native of Columbia, South Carolina, and a brother of General Fair of Montgomery, Alabama. This partnership continued until Dr. Fair's death on December 14, 1855.

Soon after Dr. Fair's death, Dr. Mabry formed a partnership with Dr. James Kent. This allowed Dr. Mabry to continue spending the warm summer months at Shelby and Blount Springs. He had enjoyed an extensive and lucrative practice from the start in 1843 and he needed to rest during the hot months.

The Alabama Medical Society was organized at Selma on April 2, 1838, and it seems that it was the first medcial organization in Alabama. It received a charter from the Alabama Legislature in 1841 as the Medical Society of South Alabama. After the Civil War, the organization was chartered as the Selma Medical Society and later on, it was chartered by the Medical Association of the State of Alabama, as the Dallas County Medical Society in 1875.

At a meeting of the local Medical Society in the office of Fair and Mabry, on December 2, 1844, Dr. A. G. Mabry was elected to the office of secretary and treasurer. He held the office by annual reelection until the annual session in December, 1850 when he was elected to the presidency.

At the annual meeting of the Medical Society of South Alabama, held in Cahaba in December, 1844, it was resolved that a silver



Mr. Albert G. Mabry

Sir,

You are hereby informed that your Examination by the Medical Faculty, for the Degree of Doctor of Medicine, has been satisfactory.

I am, very respectfully,

your obedient servant,

W. E. HORNER, *Dean.*

University of Pennsylvania, March 7th 1837

cup with a suitable inscription be awarded for the best essay on the pathology and treatment of congestive fever. Three essays were received and Dr. Mabry's essay won the prize. In his essay, Dr. Mabry proposed two doctrines as suggestions: 1. that Malaria acted primarily on the nervous system and 2. that the sulphate of quinine if properly administered will never fail to arrest a paroxysm of intermittent fever, whether it be simple, inflammatory or congestive.

During the yellow fever epidemic in 1853, Dr. Mabry was one of those who remained at his post while all others that could, ran away. The epidemic lasted from about the first of September until the first killing frost on October 25th. Two physicians had the fever and one died. Dr. Mabry presented a writtten report of the epidemic to Dr. Edward H. Barton, Chairman of the commission appointed by the city of New Orleans to collate facts of the yellow fever epidemic of 1853. Part of Dr. Mabry's report was incorporated on page 109 of the book which was published by the City Council of New Orleans.

On page 114 of the book of records of the Alabama Medical Society, we find that a call meeting was held on Wednesday, June 23, 1847 and the following minutes are of particular interest: "It was also resolved, that the secretary of this society, Dr. Mabry, be requested to make the proper investigation respecting the fitness of the Old State House at Tuscaloosa for a lunatic asylum, and the

probable amount it would cost to fix it up for such a purpose." The idea of providing for the insane in Alabama originated in the Dallas Society. Although Dr. Mabry's mission to study the possibility of using the State House at Tuscaloosa for an insane hospital was not fruitful, he never lost interest in the mentally ill citizens.

On March 10, 1858, Governor Andrew B. Moore commissioned Dr. Albert G. Mabry, trustee of the State Hospital for the insane persons in Alabama. He was one of the first seven permanent Trustees appointed by Governor Moore and excepting a brief intermission, held that office until the day of his death. The cornerstone of the Alabama Asylum for the insane was laid on July 14, 1853, with the trustees, the Governor of Alabama and other dignitaries in attendance. On December 30, 1859, Dr. Peter Bryce wrote to Dr. Albert Gallatin Mabry making formal application for the office of Physician to the Alabama Insane Hospital. Dr. Bryce became the first superintendent of the Hospital on July 1, 1860, and the first patient was admitted on April 5, 1861.

Dr. Peter Bryce, Medical Superintendent of the Alabama Insane Hospital, spoke at the annual Meeting of the State Association in 1874 in Selma, concerning the role played by Dr. Mabry in establishing the Insane Hospital. He said; ". . . he exhibited, far in advance of the profession at large in the State, and perhaps of any individual member of it; a deep interest in the treatment and cure of insanity. . . . he was the first to discover the necessity of an institution exclusively to that purpose. . . at a meeting of the Medical Society of the State of Alabama in 1850, he introduced and advocated his scheme for the erection of a hospital for the exclusive care and treatment of the insane. . . . the invincible will and determined energy of Dr. Mabry bore a conspicuous part and were instrumental, to a great extent, in securing the passage of the Act of Incorporation."

The July 2, 1933 issue of the *Birmingham News* states that Mr. W. S. Mabry and Miss Virginia Mabry, of Selma, son and daughter of Dr. Mabry, presented an oil painting of Dr. Albert Gallatin Mabry to the Alabama Insane Hospital.

In 1857, Dr. Mabry's personal popularity induced the Democratic Party of Dallas County to run him as their candidate for the lower house in the State Legislature. The County had been a Whig County for years, but with Dr. Mabry and Thomas C. Irby as standard bearers for the Democratic Party, they won easily. Dr. Mabry was reelected every two years up to 1862. He served during the stormy times of 1860-1862 and actually was a States Rights Democrat. The Republicans took over from 1862 to 1866 but Dr. Mabry was reelected for the 1866-67 session. He served for a time as Chairman of the Committee on Ways and Means. The reconstruction Acts of a Vengeful Congress disfranchised him and thus he turned his attention to the practice of his profession. He not only lost his slave property, but also his cotton, which had been saved from the demands of the war, was consumed by fire while stored on the plantation in Sumter County.

There have been no records found to show that Dr. A. G. Mabry ever enlisted in either the Confederate Army or the Confederate Navy. Because Selma was inland and on the Alabama River, it was selected as the location for the Naval Foundry of the Confederacy. It is just possible that Dr. Mabry may have treated personnel at the Foundry since most of the local physicians were in some branch of the Confederate forces. Dr. Mabry was a member of the State Legislature when the Civil War started. Regardless of the trumped-up charges against Dr. Mabry, he had to go through the process of obtaining a pardon.

Andrew Johnson, President of the United States of America, pardoned A. G. Mabry on October 18, 1865, for all offenses by him committed arising from participation, direct or implied, in the said rebellion. Dr. Mabry's oath bearing the date of October 17, 1865, was in the form prescribed by the President's Proclamation of May 29, 1865. However, a letter by James Q. Smith, U. S. District At-

torney, dated March 27, 1866, is of interest as to the cost of obtaining a pardon. The letter started out with the heading, U. S. America vs. A. G. Mabry and stated that the defendant had been specially pardoned by the President, he having paid 100 dollars, Attorney's, Marshal's and clerk's fees. That was not the end of Dr. Mabry's embarrassment and trouble, as indicated by the following letter addressed to the Judge of Probate of Dallas County.

"I, A. G. Mabry, a citizen of Dallas County, State of Alabama, do make this application for the removal of disabilities imposed on me by the second clause, of the third section, of the seventh article, of the Constitution of the State of Alabama, and to be restored to the rights of citizenship," September 17, 1868.

Signed

A. G. Mabry

It seems that Dr. Mabry was one of the prime movers in the work of organizing the State Medical Association. On December 7, 1846, the Selma Medical Society adopted the following resolution:

"Resolved, that the society recommend a State Medical Convention to be held in the town of Selma, on the fourth monday in March next, and the secretary of the society be instructed to correspond with other medical societies of the State on the subject, and the result of his correspondence be made known to this society at its next meeting."

At a meeting of the Selma Medical Society, held in Selma on June 23, 1847, Dr. Mabry submitted the following report:

"The secretary having been iinstructed at the last annual meeting of the society, to correspond with the different medical societies of the state, for the purpose of ascertaining their views upon the subject of the propriety of holding a State Medical Convention, reports that so far as he had been able to learn there was but one medical society in the state except our own, and that one was the Mobile Medical Society. He read a copy of a communication which he had, in obedience to instructions, addressed to that society, containing a proposition for the holding of a State Medical Convention, and the reply thereto, agreeing to the suggestion of this society for the holding of such a convention on the second monday in December next, and proposing Mobile as the place."

The secretary also laid before the society letters from Dr. James Guild of Tuscaloosa, and Dr. H. V. Wooten of Lowndesboro, each expressing their approval of the suggestion. Then a motion was made as follows:

"Resolved, 1st. That a State Medical Convention be called to be held in Mobile on the second Monday in December next, 2nd. That all gentlemen of the medical profession in this state, and particularly the members of the different examining boards, be invited to attend the convention, and that we earnestly request the cooperation of the Mobile Medical Society in extending this iinvitation."

Actually, the Medical Convention met on Wednesday morning, December 1, 1847, at the Waverly House, Mobile for the purpose of organizing a State Medical Society. The proceedings of the convention for Thursday, December 2, 1847, listed the following as the first regular officers of the Medical Association of the State of Alabama:

President, Dr. W. B. Johnson, Perry

First Vice-President, Dr. R. Lee Fearn, Mobile

Second Vice-President, Dr. A. G. Mabry, Selma

First Secretary, Dr. G. F. Pollard

Second Secretary, Dr. W. B. Crawford

Treasurer, Dr. George A. Ketchum

Thus, the Medical Association of the State of Alabama was founded and our subject,

Dr. Mabry, was definitely involved in establishing the organization.

After the 1866-67 session of the State Legislature, Dr. Mabry's political life ended and he offered again for the practice of medicine. Although, he attempted to bring himself up to date with the late medical theories and instruction, his practice was never what it had been before he was elected to the State Legislature.

Dr. Mabry aided in reorganizing the local Medical Society. During his membership in the legislature, he was successful in securing a new charter and changing the name to the "Selma Medical Society." He was the second President of the Society after the War, being elected soon after his return to private life.

It was while Dr. Mabry was president of the Selma Medical Society in 1868, that representatives of the Mobile, Montgomery, Greensboro, and Selma Societies with a few other physicians met in Selma with a plan to reorganize the Medical Association of the State of Alabama. The convention was held on March 3rd and 4th, 1868. Dr. Mabry was elected President and presided over the two day session.

The next annual session was held in Mobile, on March 2-4, 1869, with Dr. Mabry presiding. His presidential address was on, The Medical Profession. He presented another paper during the Mobile meeting and the title was "Miasmatic Fevers."

It seems that Dr. Mabry was a general practitioner who did not perform much surgery. However, he treated successfully all cases of fractures, amputations and minor surgery that came for aid. He was not a prolific writer. His few articles appeared in the transactions of the State Association. In addition to his presidential address, he wrote on the diseases of Dallas County; Indigenous Botany of Dallas County; Observations on the Medicinal properties and Therapeutic Application of the sulfate of Quinine; Haemorrhagic fever; Adhesion of the Vagina and Miasmatic Fevers.

The various railroad enterprises that served Selma demanded considerable interest and leadership from Dr. Mabry. At one time he was vice-president of the Selma, Rome and Dalton Railroad. He was also listed in the directory of the old Selma and Meridian Railroad.

The subject of our sketch was of medium physical structure, being about 5 feet and 8 inches in height and of about 140 pounds in weight. Dr. Mabry had a dark complexion with black hair and brown eyes. He generally wore a full beard, but well trimmed. He never used tobacco and rarely used alcoholic liquors. It seems that he was one of those small wiry men who was rarely ever seriously ill, but was watchful of his personal health. He spent his summers at his summer residence at Blount Springs until after the Civil War.

In July 1845, Dr. Mabry married Mrs. Martha Riggs Tartt, widow of Thomas E. Tartt, who was associated wtih Stewart and Company . . . commission merchants of Mobile. Mrs. Tartt had one child by this marriage, a daughter, Gertrude, who married Catesby ap Roger Jones, Captain in the Confederate States Navy. The widow Tartt and her daughter were well off financially, and it was through this marriage that Dr. Mabry became associated with Governor John A. Winston, who was Miss Tartt's guardian. The association of Dr. Mabry with Governor Winston lasted until the latter's death. There were six children born of the marriage of Dr. Mabry and Mrs. Tartt:

1. Albert Gallatin. July 6, 1846
2. Daniel Riggs. July 11, 1848
3. William Spark. December 30, 1849
4. John Winston. June 22, 1852
5. Virginia. June 7, 1854
6. Richard Henry. February 1857

He was a prominent member of the Protestant Episcopal Church. He served as a member of the Vestry of the Parish of St.

Paul's Church, Selma, for more than thirty years and was Senior Warden for many of those years.

For some years before his death, Dr. Mabry seemed to be badly nourished and light in his weight. No doubt, his general poor health accounted for the fact that his death was due to pneumonia. He died on February 23, 1874, and was buried in Live Oak Cemetery, Selma.

One of his colleagues in the Legislature, The Hon. James M. Calhoun, had the following to say about Dr. Mabry:

"To the Insane Asylum he devoted all his energies. . . was a man of fine common sense; well informed; very cautious in the formation of opinions, but once formed, he was very tenacious of them. . . As a speaker, he did not pretend to ornament as eloquence, but was always sensible, impressive and pleasant . . . his purity of character, his high integrity, his perfect reliability and frankness, his pleasant good nature, I very often recall . . . feel an humble pride that I was permitted to rank such a man among my friends as I am sure he was."

Dr. George A. Ketchum at the 1874 session of the State Association made the following remarks concerning the death of Dr. A. G. Mabry:

"The Medical Association of the State has lost one of its earliest originators, and one of the first promoters of its efforts—one of the most steadfast of its friends—one of the most honored of its fellows . . . his name erased from the roll of the organization, will henceforth be found on that of the venerated dead. . . the medical history of Alabama and its State Association would be incomplete indeed did not the name of A. G. Mabry adorn its brightest page. . .His brain conceived this organization; for it in its helpless infancy; he succored it in its days of progress; and now, when in its approaching maturity he dies, he bequeaths to it the honors inseparably connected with his example and name. . . . Whilst we drop a tear on his newly made grave, let us rejoice and be proud that he so honored his profession in his life."

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Voluntary Health Insurance Programs And Their Effects on the Physicians' Fee Structure

Paul Burleson, M. D.

I. Preamble

With the nation's medical care cost nearing the $50 billion a year mark, more Americans than ever before—four out of every five—are covered by some form of private health insurance (1967 figures). According to the Social Security Administration $47.3 billion was spent in 1967 for health and medical care in the United States, a record $4.5 billion increase over fiscal 1966. The share of the gross national product being spent for health also continued to rise—from 6 per cent in fiscal 1966 to 6.2 per cent in 1967. The health share of the gross national product has risen 75 per cent since fiscal 1929 when it was 3.6 per cent. Despite these overall gains in health care and spending, in 1967, the private expenditures for health declined from the 1966 level of $31.7 billion to $31.1 billion. Causing this decline are the new federal programs of Medicare and Medicaid. These programs reduced direct payment by consumers to providers of services and increased the amount of health expenditures in the public sector. As a result, private funds paid for only 66 per cent of all health and medical



Dr. Burleson

care expenditures in 1967 down from 74 per cent in fiscal 1966, while public funds share of health spending were 34 per cent in 1967, up from 26 per cent the year before. Public expenditures for health care rose sharply in 1967—more than $5 billion—to $16.2 billion from $11 billion in fiscal 1966. Except for one year during World War II when expendi-

tures almost doubled due to the health care requirement of the military services, this was the largest increase in history. An estimated 158,022,000 persons or about 81 per cent of the nation's civilian, non-institutionalized population have some health protection against hospital care. The figure includes about 148,589,000 persons age sixty-five and over. Percentage-wise Blue Cross-Blue Shield enrollment was 38.7 per cent of those with hospital coverage and 37 per cent of those with medical-surgical coverage. A total of 97,404,000 persons had hospital coverage offered by insurance companies and 90,-294,000 were covered with surgical expenses by insurance firms. In terms of percentages, insurance companies covered 57.4 per cent of those with hospital coverage and 57.7 per cent of those with surgical coverage. Independent plans provided hospital insurance for 3.9 per cent of the total number covered and 5.3 per cent of those persons covered for surgical expenses.

II. Medical Fee Concept

The original concept of doctors' fees was that of a simple contract. This was a time-honored relationship of a fee for a professional service being paid by the patient to the physician.

In recent years, newer concepts in the fee structure for payment to physicians have occurred—largely since the close of World War II. I refer to the so-called third party involvement in payment for medical service. Initially, some of the large private insurance companies throughout the country initiated sick and accident insurance policies to help in paying the medical-surgical and hospital expenses. As experience in this field was gained by these companies, others entered the field resulting in hundreds of various contracts offering varying degrees of participation in paying medical care and costs. It is estimated that at the present time there are over *800* of these in the United States.

The Blue Cross-Blue Shield plans representing a non-profit cooperative medical care insurance came onto the scene prior to World War II but really began to expand in the immediate post-War era. In addition, other plans arose such as the Union Health Plans as exemplified by United States Steel and United Auto Workers, who contract out their work to either private insurance carriers or to Blue Cross-Blue Shield. In addition, there are the so-called industrial health and welfare funds such as the United Mine Workers of America which administer their own funds through closed-panel clinics and hospitals.

III. Types of Insurance Payment

With this background, I would like to now discuss the types of insurance payment. Historically the time-honored method of insurance payment for health care has been the so-called indemnity type of payment. This is a fixed fee for a given service representing a partial payment of the doctor's overall fee. This fee in many instances is rather a small part of the overall fee and it becomes the responsibility of the physician to collect the remainder of the fee from his patient. Obviously this type of fee structure has not been satisfactory to the practicing physician inasmuch as stated it is a fixed fee and has not in most instances kept up with the escalating rise in medical care costs.

As a result of this inadequacy, the relative value index plan was initiated in California in early 1950's. This plan attempts to avoid "fixing fees." All of the various medical, surgical and laboratory procedures under this plan are numerated and coded. To each of these, a relative value unit is assigned. No dollar value is affixed. For example, an office visit might be assigned one unit and an appendectomy thirty units. In this case if $5.00 is assigned to the fee for an office visit, the appendectomy would be thirty times $5.00 or $150.00. This allows for variation in fees in different geographic areas (based on overhead, specialty type practice, etc.) and also allows an orderly way of increasing fees to keep up with rising costs of living. This concept of relative value index has met with considerable success in certain areas but as in the case of the indemnity type fee has not

met all of the needs of a changing socio-economic climate.

As a result, within the past four or five years, a new concept referred to as the prevailing fee concept has come on the scene. In this case, again a list of all the various medical, surgical and laboratory procedures are enumerated and this time the physician assigns his usual fee in dollars to each procedure. All of the physicians who agree to participate in this plan agree to abide by the charges which they have submitted and sign a contract with a carrier to that affect. The fee for each service is then taken from each physician's list and put on the computer and all the fees for a given procedure which fall within the 90 percentile of what all other physicians in the area are charging, is paid. Only the upper 10 per cent of those fees which are higher than the usual fees are subject to question. It is possible that every physician's fee for a given service in a given community could be paid if all fell within the 90 per cent range. The prevailing fee concept is still experimental in Alabama with the Jefferson County Medical Society working in conjunction with Blue Cross-Blue Shield initiating this plan as a pilot study in 1966. Obviously this type of plan is subject to some criticism, inasmuch as it necessitates the participants in the plan signing a contract with the carrier regarding the fees which he agrees to charge, based on his own profile.

Most recently and within the past two or three years, a new concept has arisen which is referred to as usual and customary fees. Again a profile for each physician is set up and in this case, the physician submits a claim for his usual fee for a given service to the carrier. It will be paid if it is in line with the fee profile and with the fees charged for the same procedure by the great majority of physicians in his own specialty and geographic area. The fee cannot be raised unless written notice is given 90 days in advance. If the usual fee falls within the prevailing range of some 90 per cent of the physicians in a given area as determined by the 90 per centile method, the plan will pay it. The plan will not pay anything higher unless it can be medically justified. With this background, let us go briefly into the philosophy of the newer concept of usual and customary.

Like medicine, health coverage evolves by building upon the technology and experience that have served its purposes in the past. New developments seldom appear overnight and when they do, they tend to be suspect until a testing period confirms or disproves their value. Programs to pay the usual and customary charges of physicians are emerging from such a period.

The nomenclature preceded the product. As originally applied by commercial insurors, the terms "usual and customary" referred to unpublished fee schedules, derived by carriers from their own claims experience. Claims falling within these schedules were

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paid; others were negotiated: some successfully, some not.

More recently, some Blue Shield Plans conferred specific meanings upon the terms. "Usual" defined the charge of a particular physician to his patients of normal means for procedures of normal difficulty. "Customary" referred to the range of charges of comparable physicians in the same geographic or economic area for the same procedure.

In combination, these concepts then described as "reasonable" a charge which was normal for the physician making it and compatible with those of his peers. The Medicare legislation's adaptation of this refined approach gave broad currency to the idea and accelerated the movement away from fee schedules.

The tool that made this possible was the computer with its ability to store and retrieve vast amounts of charge data. For the first time, it became possible to ask of a given claim: "Is it usual? Is it customary?", and receive answers that manual processors could not have provided.

Affirmative answers result in individualized payment. Negative ones activate an individual consideration process that is part of all Blue Shield usual and customary programs. Claims that exceed normal levels are reviewed first by medical staff and again if necessary by professional review committees, to evaluate special circumstances which might justify additional payment. The Plan's commitment in such programs is to payment in full, and extraordinary circumstances warranting extraordinary charges are anticipated and accommodated.

Programs without fee schedules offer new opportunities and new hazards to physicians and to their Blue Shield Plans. A fee schedule is always a compromise. If it is to be "realistic" for a community, it will be inflationary for some charges and inadequate for others. A change in the schedule modifies the inequity and sometimes does little more. The ability to divorce payment from these schedules permits the Plan to meet charges as they are, and to get optimum use of the patient's health care dollar. But the increased freedom brings increased responsibility for the medical profession.

The National Blue Cross has now taken the position of requiring each state plan to offer paid-in-full programs based on "usual and customary" fees. Fifty-nine plans now offer such programs as compared with fifteen at the end of 1966.

The chief problem of course at the present time is selling these contracts. At the present time in Alabama, it requires a group of fifty or more participants in a group and it is obviously more expensive than an indemnity plan and thus is more difficult to sell. There are two manners in which the cost can be lowered to the subscriber and that is through a co-insurance factor which can be added. By this is meant the plan would pay only a given per cent of the usual and customary (90, 80, 70 per cent, etc.) leaving the remainder to the physician to collect. The other way in which the expense can be lowered is to limit the amount of coverage or the number of procedures covered in the given contract.



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Continuing Education A Part Of Teaching Responsibility

(DIVISION OF CONTINUING MEDICAL EDUCATION
MEDICAL COLLEGE OF ALABAMA)

* "The education of the doctor which goes on after he has had his degree is after all the most important part of his education"—John Shaw Billings

In April of 1968 the Division of Continuing Medical Education of the Medical College of Alabama was surveyed for accreditation by the American Medical Association through its Council on Education. The survey team consisted of John H. Killough, Ph. D., M. D., Assistant Dean, Jefferson Medical College, and Glen E. Garrison, M. D., Medical Director of Continuing Education, Medical College of Georgia. The result of the survey was Approval for Accreditation by the American Medical Association.

The letter of accreditation was accompanied by a detailed report made by the survey team and included a number of recommendations which will prove helpful in planning and future developments for the Division of Continuing Medical Education. The summary of the report follows:

General Quality of Overall Program—There was no doubt in the minds of the site visitors but what the quality of the educational programs presented is good. Certainly the faculty of the Medical College of Alabama used in these programs was excellent. The problems of a continuing medical education program in Alabama are quite different from those in many other areas and must be taken into consideration. In the state, which is the third largest east of the Mississippi, there are only 2,400 physicians (approximate). Doctors are widely scattered and in some counties there are only two or three practitioners. This creates difficulty for physicians in obtaining patient coverage so as to permit attendance at courses. It is also of interest that outside of Birmingham there are only two hospitals with house officers. Indeed, most of the hospitals are of the order of 100 beds. Under such circumstances the demands on physicians are quite heavy, and this no doubt contributes significantly to the relatively small attendance at many courses. It was definitely not the impression that the quality of programs was a limiting factor. The site visitors did discuss with Dr. Klapper and others the desirability of taking some of the instruction out into the field. Planning for this type of activity is in progress, and Dr. Wells of the Alabama Regional Medical Program will be most helpful in supporting these efforts. There are limited television facilities, and growth in this area is anticipated. This is a young medical school (20 years old), and it is vigorous. The site visit team has confidence in the success of getting the excellent programs to more physicians. (How to get the 75 per cent who do not go to programs of instruction in any part of the nation is probably as prevalent in Alabama as elsewhere. The site team is unaware of any satisfactory solution to this pressing problem.)

Recommendation for Approval, Resurvey or Disapproval—The site visit team strongly recommends that this program be approved for accreditation. Strong aspects of the program are as follows:

1. An excellent medical center and faculty.
2. A strong administrative commitment to a program of continuing medical education.
3. Strong faculty support of continuing medical education.
4. Evident interest in the problems of phy-

* Boston Medical and Surgical Journal, 131:140, 1894.

sicians in keeping well informed and the willingness of the faculty to teach practitioners.

It is the opinion of the site visitors that the following aspects of the C. M. E. program need to be strengthened:

1. Better documentation of the financial aspects of the program—both income and expenses.
2. A planned expansion of the budget to accommodate the needs and plans for this most rapidly growing area of medical education.
3. The Director of the program needs a full-time quality administrative assistant. If this individual could be an education psychologist, this would strengthen considerably the planning and evaluation aspects of the program.
4. There needs to be a better definition and/or communication of the responsibilities and the services from the Division of Continuing Medical Education to the faculty of the Medical Center.
5. There needs to be further consideration given to the real need for the presentation of a variety of off-campus programs.

The recommendations emphasized needs and trends well recognized by the Medical College and the Division of Continuing Medical Education. An earnest effort was already underway to strengthen the off-campus educational program through the extramural programs which are now being held in a number of areas throughout the state. Services of an administrative assistant, Mr. Robert Shaw, are available. Without his assistance it would have been impossible to implement the extramural programs. The plan for Physician Consultation and Communication is another step toward bringing information to the physician within the climate of his practice. The first step of this plan, the Telephone Information Service, should be implemented within the next few months.

The recommendations concerning the financial aspects of the program and a planned expansion of the budget pose the question as to how the financial needs of continuing medical education in Alabama should be met.

In expressing and accepting a responsibility for continuing medical education, an institution must either assume financial support of such a program or seek its support from other sources. The cost of medical education is great at both the undergraduate and postgraduate (internship and residency training) level and it is likewise costly for continuing medical education. It is generally recommended that physicians contribute toward the support of continuing education programs through fees and tuition, portions of the dues of their organized societies or through contracts with community hospitals. Just as the tuition of an undergraduate medical student is insufficient to support his education, these sources of financial support are inadequate for any program of appreciable magnitude in continuing medical education.

Exploration of the source of financial support at other institutions reveals tremendous variations both in source of support and adequacy of support of their programs in continuing medical education. A few departments of continuing education report themselves to be completely self supporting through contracts with community hospitals for educational programs for their house staff and physician staff, fees for individual programs, consultation services to other institutions, and grant support for particular endeavors. This may occur when the institution is in a heavily populated area where there are many large community hospitals with approved house staff programs and little or no affiliations with medical schools. State universities may receive appropriations from the legislature, the state health department or the state medical association toward the support of continuing medical education. In

one state questioned, the annual budget was $250,000, largely derived from the state, the state medical association, and the state health department. Some institutions seek grant support from philanthropic societies, federal agencies, and pharmaceutical companies. In many instances, the program is insufficiently financed, and the deficit is absorbed by the institution or the program withers. At the Medical College of Alabama, tuition and fees have contributed somewhat toward support, and additional support has been obtained in modest amounts from pharmaceutical companies, training grants, and community or Veterans Administration hospitals.

It has been the philosophy of the Medical College that continuing education is a part of the teaching responsibility of its faculty, and specific remuneration or honoraria are not provided except for extramural programs wherein the faculty member participates outside the confines of the Medical Center. As services in continuing education are expanded, it is to be expected that it will be a determinant factor in the total number of full-time faculty required at the Medical College, and it might be anticipated that each department have in its budget a proportionate amount for continuing medical education which would be directed toward general faculty support and general support within the department.

At the time the survey was made by the team for accreditation of the American Medical Association in April of 1968, some documentation of funds and cost was required including some monetary value to the faculty time utilized. Documentation of fees and grant or contract support was possible, but much of the costs of the Division was difficult to ascertain because it was disbursed throughout the administration and departments and was difficult to identify. A conservative estimate for the year 1967-68 was:

Physician Fees Collected	$ 3,855.00
Grants and Other Sources of Support	33,456.00
Total	$ 37,311.00
Expenses Paid for Individual Courses (printing, mailing, travel, guest speakers, etc.)	$ 38,398.41
Estimated Division Salaries	19,500.00
Estimated Cost Faculty Time	25,000.00
Estimated Cost Facilities (business office, facility service, etc.)	28,633.85
Total	$111,532.26

It can be readily recognized that if the responsibilities of the Medical College for continuing medical education are to be met that a sound and planned expansion of the budget will be necessary. Financial support will be requested in the budget request of the Medical College to the legislature and from various granting agencies where feasible and appropriate. It is also requested that the physicians of Alabama either individually or through their state organization assist the Medical College in a better definition of its responsibilities and services in continuing medical education and in the financial support of these endeavors.



The Month in Washington

From the Washington Office
American Medical Association

Washington, D. C.—The Department of Health, Education and Welfare issued proposed regulations setting standards for rubella vaccine, making it possible it will be ready for distribution in limited quantities by about June 1.

The standards cover production methods, safety, purity and potency. They were developed by the Division of Biologics Standards, a unit of the National Institutes of Health. Final regulations could be published as early as May 3. Indications were that two manufacturers would have a vaccine ready for initial distribution soon after the regulations had been made final.

"This means that we are one step closer to the prevention of a disease that has caused an untold number of tragic births," HEW Secretary Robert H. Finch said when the proposed regulations were issued.

"We are moving ahead to combat German measles in the quickest manner consistent with public safety."

The regulations apply to vaccines containing a live virus strain known as HPV-77, which is grown in either duck embryo or dog kidney cell culture systems. Experimental vaccines produced in accordance with the standards have undergone extensive community testing in the United States and abroad. Two manufacturers, Merck, Sharpe & Dohme and Philips Roxane Laboratories have produced vaccines based on this strain.

"We hope that more than one vaccine will be available," Dr. Robert Q. Marston, NIH Director, said. "Regulations covering the use of other virus strains and culture media for rubella vaccine production will be formulated on the basis of extensive tests now going on."

Smith, Kline & French Laboratories has tested widely an experimental vaccine containing the Cendehill strain of rubella virus.

An HEW announcement said:

"German measles is a threat to susceptible pregnant women at any time, but the threat increases significantly during epidemic years. One of the most tragic and disastrous epidemics to hit the United States in modern times was the German measles epidemic of 1964-1965. This resulted in about 50,000 abnormal pregnancies. About 20,000 infants were born with such crippling defects as mental retardation, heart disease, blindness and deafness. The remaining 30,000 pregnancies terminated in miscarriage or stillbirth.

* * *

The Food and Drug Administration has taken the first step to halt the marketing of 78 antibiotic combination products.

The ultimate action was recommended by the National Academy of Sciences-National Research Council, which is evaluating the effectiveness of about 3,600 new drugs marketed from 1938 to 1962.

Generally, the 78 products were found ineffective as fixed combinations for claims made in their labeling. The FDA emphasized that this does not necessarily mean that either the antibiotics or other active ingredients of the products are ineffective when used alone.

"But the use of two or more active ingredients in the treatment of a patient who can be cured by one is irrational therapy," said Herbert L. Ley, Jr., M. D., Commissioner of Food and Drugs. "It exposes the patient to an unnecessary risk. Antibiotics should be used like a rifle rather than a shotgun."

The majority of the 78 products are anti-

biotic-sulfa combinations in tablet, capsule, or liquid form. Also included are 16 penicillin-streptomycin combinations that are given by injection.

Other antibiotics used in the preparations include erythromycin, neomycin, tetracycline, chlortetracycline, nystatin, oxytetracycline, oleoandomycin, and triacetyloleoandomycin. In addition, some of the preparations contain analgesics, vitamins, or other ingredients.

The antibiotics combinations are the products of 21 different manufacturers, including Chas. Pfizer & Co.; Eli Lilly & Co.; Lederle Laboratories division of American Cyanamid Co.; Bristol Laboratories Inc., a division of Bristol-Myers Co.; Merck & Co.; E. R. Squibb & Sons Inc., a subsidiary of Squibb Beech-Nut Inc.; Upjohn Co.; Wyeth Laboratories Inc., a subsidiary of American Home Products Corp.; Abbott Laboratories; and Hoffman-La Roche Inc. In an earlier proposal last December, the FDA similarly moved against products marketed by Squibb, Lederle and Upjohn.

Many of the affected products have been promoted widely and have found wide acceptance in the medical profession. Several of the manufacturers promptly said they would contest the FDA ruling and others were expected to oppose it also. The manufacturers were given 30 days to submit any new data on efficacy of the products.

There were 12 products in the first groups, announced last December. A decision still was pending on whether manufacturers of those products should have additional time to submit evidence of efficacy.

The FDA can halt the marketing of antibiotic-containing preparations by deleting them from regulations listing the antibiotic drugs acceptable for certification. Antibiotics and insulin, unlike other drugs, must be certified on a batch-by-batch basis before they can be marketed.

* * *

Two spokesmen for the medical profession asserted before a Senate subcommittee that the policies and scientific journals of their organizations are not biased in favor of the prescription drug industry because of the drug advertising revenue.

Sen. Gaylord Nelson (D., Wis.), chairman of the Senate Monopoly Subcommittee which is making a broad study of the ethical drug industry, accused the medical journals of following the pharmaceutical industry's line to get advertising dollars.

Both Dr. Edward R. Annis, a member of the AMA Board of Trustees, and Dr. Maynard I. Shapiro, president of the AAGP, emphatically denied the charge. Both cited the high, objective advertising standards of their organizations' publications.

"The American Medical Association's programs and policies have never been, are not now, and will never be shaped by any dependence on the drug industry," Dr. Annis said. "And to assure that there is no conflict of interest, the AMA has consistently separated the editorial management, advertising acceptance, and business management of each of its scientific publications . . .

"We believe that no publication surpasses our own standards for acceptable advertising."

Nelson sharply criticized the Journal of the American Medical Association as to the ads it carried on chloromycetin after the drug had been judged to be extremely dangerous. Annis acknowledged that "one Madison Avenue effort. . . slipped through the net" of AMA advertising standards. But he pointed out the various warnings on the drug carried in the editorial content of JAMA and other AMA publications.

"Advertising is screened by a group of physicians, all of whom we consider qualified to perform their task," Dr. Shapiro said. "We don't list the names of these physicians in our magazines because we believe they prefer a degree of anonymity. All are medical school faculty members and all, in our opinion, are well qualified to screen pharmaceutical advertising."

Dr. Shapiro also said that at least two drug firms had canceled ads in AAGP publications after they had carried editorials adverse to the companies.

* * *

The Nixon Administration recommended to Congress that the Hill-Burton hospital construction and improvement program be changed to permit block allocation of grant funds to states.

Since enactment of the first Hill-Burton legislation in 1946, federal grants for it have been earmarked for specific purposes.

In a statement to the House Health Subcommittee, Robert H. Finch, secretary of Health, Education and Welfare, said the nation's health needs had changed since the Hill-Burton program was started.

Today's needs, he said, are twofold:

—Modernization or replacement of existing and obsolete acute care facilities in the hospitals and

—Expansion of other kinds of medical facilities to reduce the pressures on hospitals and help curb skyrocketing medical costs.

He recommended a $150 million annual grant authorization for construction, replacement or modernization of the most critical types of health facilities.

"Additionally, we recommend the removal of the existing Hill-Burton categories to provide a better balance of health care facilities in the community by assisting those kinds of facilities which have traditionally been neglected or in short supply," he said.

Expansion of neighborhood health center programs also was recommended. The HEW statement said it was required to meet the health needs of the poor.

H. Phillip Hampton, M. D., Tampa, Fla., testifying for the AMA, said the AMA continues its long-standing support of the Hill-Burton program but believes that "the major need that exists today is for the improvement and effective use of existing facilities."

"Priority for modernization and the upgrading of existing facilities will lessen the strain on the available supply of health personnel needed to provide services obtained in hospitals and related facilities," he said.

The AMA supported a provision in one of the two Hill-Burton bills before the subcommittee that would permit states to transfer funds from one allocation to another, providing "further elasticity to the transfer of funds from contruction to modernization."

The AMA opposed as unnecessary the establishment of Hill-Burton priorities for construction or modernization of out-patient facilities or facilities to provide comprehensive health care. Such needs should be met through other laws already enacted, the AMA said. Dr. Hampton explained:

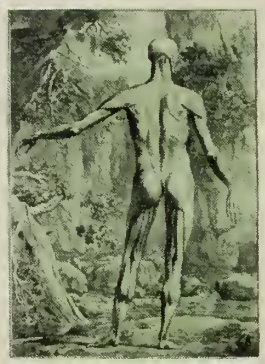
"We hope to make this point clear: We understand the part played by hospital outpatient departments in providing a place for necessary services to a community, and to the role played in teaching and training. But we believe that any need for outpatient facilities, separate and apart from the hospital, or for free-standing diagnostic and treatment centers—or whatever they may be called—can be met through other programs which provide federal assistance. The Hill-Burton program is not the appropriate vehicle for grants or priorities for such separated facilities. Nothing has been demonstrated which indicates either public benefit or public acceptance for this concept of providing ambulatory medical care through hospital operated, rather than physician operated, neighborhood clinics."

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Contraindications:
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Adverse Reactions:
Due mainly to anticholinergic action and usually at high dosage. They may include dryness of the mouth, tachycardia, palpitation, urinary hesitancy or retention, blurred vision, dilatation of the pupil, increased ocular tension, weakness, nausea, vomiting, headache, dizziness, constipation and drowsiness. Infrequently, mental confusion in the elderly, urticaria or other dermatoses. Adverse reactions are usually eliminated by reduction in dosage. Two cases of aplastic anemia, with no established causal relationship, have been reported.

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Two tablets per day for adults, regardless of weight or sex; one in the morning and one in the evening. Each tablet contains 100 mg. orphenadrine citrate.

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BUREAU OF VITAL STATISTICS
PROVISIONAL BIRTH AND DEATH STATISTICS AND COMPARATIVE DATA

Ralph W. Roberts, M. S., Director

December 1968

Live Births Deaths Causes of Death	Number Registered During December 1968			Rates* (Annual Basis)		
	Total	White	Non-White	1968	1967	1966
Live Births	5,636	3,818	1,818	18.5	17.5	18.6
Deaths	3,013	2,005	1,008	9.9	10.1	9.3
Fetal Deaths	104	50	54	18.1	21.3	18.9
Infant Deaths—						
under one month	106	64	42	18.8	17.2	22.0
under one year	168	92	76	29.8	29.1	33.0
Maternal Deaths	2	—	2	3.5	11.1	3.5
Causes of Death						
Tuberculosis, 001-019	19	11	8	6.2	7.6	5.7
Syphilis, 020-029	5	—	5	1.6	3.0	0.7
Dysentery, 045-048	—	—	—	—	—	—
Diphtheria, 055	—	—	—	—	0.3	0.3
Whooping cough, 056	—	—	—	—	—	—
Meningococcal infections, 057	3	1	2	1.0	1.3	1.3
Poliomyelitis, 080, 081	—	—	—	—	—	—
Measles, 085	—	—	—	—	—	—
Malignant neoplasms, 140-205	413	313	100	135.3	143.1	119.0
Diabetes mellitus, 260	44	30	14	14.4	19.8	22.1
Pellagra, 281	—	—	—	—	—	—
Vascular lesions of central nervous system, 330-334	388	255	133	127.1	126.9	123.0
Rheumatic fever, 400-402	1	—	1	0.3	0.3	0.7
Diseases of the heart, 410-443	1,008	724	284	330.2	350.6	295.6
Hypertension with heart disease, 440-443	121	54	67	39.6	40.6	34.4
Diseases of the arteries, 450-456	78	49	29	25.6	20.2	20.1
Influenza, 480-483	8	6	2	2.6	4.0	1.0
Pneumonia, all forms, 490-493	99	64	35	32.4	37.0	34.4
Bronchitis, 500-502	14	12	2	4.6	3.6	3.0
Appendicitis, 550-553	—	—	—	—	0.7	1.3
Intestinal obstruction and hernia, 560, 561, 570	16	9	7	5.2	4.3	3.3
Gastro-enteritis & colitis, under two, 571.0, 764	7	3	4	2.3	0.3	2.3
Cirrhosis of liver, 581	22	16	6	7.2	7.9	7.4
Diseases of pregnancy and childbirth, 640-689	2	—	2	3.5	11.1	3.5
Congenital malformations, 750-759	32	26	6	5.7	4.7	5.2
Immaturity at birth, 774-776	24	17	7	4.3	3.8	5.4
Accidents, total, 800-962	210	151	59	68.8	61.8	83.6
Motor vehicle accidents, 810-835, 960	105	78	27	34.4	32.1	44.8
All other defined causes	425	257	168	139.2	142.4	133.4
Ill-defined and unknown causes, 780-793, 795	195	61	134	63.9	58.8	50.5

*Rates: Birth and death—per 1,000 population
Infant deaths—per 1,000 live births
Fetal deaths—per 1,000 deliveries
Maternal deaths—per 10,000 deliveries
Deaths from specified causes—per 100,000 population

APHA Holds '69 Convention

by Catherine G. Lamar

"Public Health in Transition" was the theme of the thirteenth annual meeting of the Alabama Public Health Association and the Alabama Public Health Workers' Conference which was held March 26-28 at the Admiral Semmes Hotel in Mobile. A record number of 837 members registered at the convention.

A host of talented speakers and public health specialists were recruited to share their knowledge and to bring members up-to-date on changes and trends in the profession.

"Opportunity Unlimited" was the title of the keynote address delivered by the internationally famous inspirational speaker and humorist Dr. Carl S. Winters at the first general session Wednesday at 2:00 p. m. Available to the association through the courtesy of General Motors Corporation, Dr. Winters serves as a member of the corporation's lecture staff. Over the past few years he has delivered the keynote address for more than 800 state, national, and international conventions on four continents. His itinerary has placed him before audiences in every major American city, as well as London, Paris, Rome, Cairo, Hong Kong, Calcutta, New Delhi, Bangkok, Rangoon, Leopoldville, Rio de Janeiro, Manila, Tokyo, and Honolulu.

Thursday's power packed program included presentations on "Transition in Medical Care" by Dr. Thomas H. Alphin, the state health department's director of medical services; "Alabama's Alluring Attributes" by Martin J. Johnson, manager of the Mobile District Office of the Social Security Administration; and "Appalachian Health Planning Commission—Alabama" by Barrett C. Shelton, editor and publisher of *The Decatur Daily*.



Newly elected officers of the Alabama Public Health Association are shown as follows: (L. to R. seated) Mrs. Helen Wylie, alternate delegate to the American Public Health Association; Mrs. Virginia E. Kendrick, president; (L. to R. standing) Dr. John D. Rayfield, president-elect; Forest E. Ludden, vice-president; Guy Tate, delegate to the American Public Health Association. Not shown is Mrs. Jean Formby, secretary-treasurer.

A highlight of Thursday's general session was presentation of the D. G. Gill Award to the Honorable Lister Hill, retired senator. The renowned statesman accepted the award in person and commented on health pro-

grams and progress during his 45-year congressional term.

The 11 sections of the association held meetings on Thursday afternoon from 2:00 to 4:00. Outstanding speakers presented programs in key areas of interest.

Lee-Allen Ford, education consultant with the Alabama Department of Mental Health, Division of Alcoholism, spoke on "Whose Responsibility is the Alcoholic?" to members of the Community Health Section.

The Dental Health Section program featured Dr. William M. Crosby of Ft. Deposit, Dr. J. Felton Davenport of Decatur, and Dr. Joel Goldsby, director of the Mobile County Health Department's Bureau of Dental Health, in a panel discussion on dental public health in transition.

Hospitals and municipalities were represented in a program "Emergency Medical Care" featured at the Medical Care Section meeting. Panelists included Lionel M. Laws with the Montgomery Area Chamber of Commerce; Winston C. Whitfield, administrator of the Mobile General Hospital; and William H. Eagar, administrative assistant to the Mayor of Montgomery.

Members of the Environmental Health Section sponsored the program "Sanitation in Transition" by David E. Hartley, director of public health programs for the National Automatic Merchandising Association.

Stafford Smith, deputy information officer with the National Communicable Disease Center in Atlanta, presented a filmed tour of CDC to members of the Health Education Section.

A workshop-type program was scheduled for Laboratory Section members encompassing procedural problems confronting the state laboratories and fecal coliform isolations in oysters and seafood.

Title XIX was the featured topic when Dr. Thomas H. Alphin addressed members of the Health Officers Section.

Two outstanding specialists were engaged by the program committee of the Food and Nutrition Section. Dr. Hollis J. Wiseman, pediatric consultant for the Maternal and Infant Care Project and co-director of the Department of Pediatrics of the Mobile General Hospital, spoke on "Influence of Nutrition on Total Development of the Infant." "Meeting Demands for Service" was the topic of Miss Geraldine Piper, nutrition consultant with the Bureau of Health Manpower, U. S. Public Health Service.

The program slated by the Public Health Nurses Section followed closely the general conference theme. Miss Dorothy L. Barfield, chief coordinator of nursing services with the State of Georgia Department of Health, presented "Nursing's Answer to Transition."

Following a luncheon meeting at 1:00, members of the Statistical and Clerical Section heard a program on "How to Hold An Audience Without A Rope" by Kenneth W. Jennings, district manager of the Montgomery Social Security Office.

"VD Control in a Mobile Population" was the topic for discussion when members of the Venereal Disease Section heard Jack E. Wroten, associate director of the Venereal Disease Control Program, Florida State Board of Health.

Capsule comments on "The Challenge of the Present" were provided by Dr. Ira L. Myers, state health officer, at the Friday meeting of the Public Health Workers' Conference. Special segments of the program were set aside to honor deceased and retiring members of the association. Plaques were awarded to past presidents of the association.

New officers nominated and elected at the general session on Friday included: Mrs. Virginia E. Kendrick, president, personnel officer, Alabama Department of Public Health; Dr. John D. Rayfield, president-elect, Talla-

(Continued on Page 1047)

WHAT'S SO WEAK ABOUT THE WEAKER SEX?

(Continued from Page 1043)

dega County Health Officer; Forest E. Ludden, vice-president, public health executive, Bureau of Administration, Alabama Department of Public Health; and Mrs. Jean Formby, secretary-treasurer, director of the Clerical Division, Bureau of Licensure and Certification, Alabama Department of Public Health.

Prior to adjournment, an invitation was extended by Dr. Otto L. Burton, Montgomery County Health Officer, to hold the 1970 convention in Montgomery. The members voted to accept the invitation.



The Honorable Lister Hill, retired senator, accepts the D. G. Gill Award presented by the Alabama Public Health Association during the 13th annual conference in Mobile.

Diagnosis By Television

Telediagnosis, a concept of diagnosing at a distance through closed-circuit television, medical electronics, and microwave transmission, is described in a new brochure available from Raytheon Company's Communications and Date Processing Operation, Norwood, Mass. The brochure asserts that telediagnosis has "closed the important geographic and manpower gaps in the most basic, urgent and problematic of medical functions —the doctor-patient relationship."



THE BETTMANN ARCHIVES

Just one tablet at bedtime • Prevents painful night leg cramps • Permits restful sleep

How many of your patients stamp their feet at night and lose sleep because of painful leg cramps? Unless prompted, they usually fail to report this distressing condition and suffer needlessly.

One tablet of QUINAMM at bedtime usually controls distressing night cramps and permits restful sleep with the initial dose.

Prescribing information—Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Side Effects/Precautions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

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M (for Meetings)

1. President-elect Word, Past President McCafferty, President Pitt.
2. Board of Trustees.
3. Alabama alumni: Seated: Drs. Meador and Dimick; standing: Drs. M. McLaughlin, Charles Howell.
4. Tulane alumni: Drs. Harold Cummins, E. L. McCafferty, Jr., Alton Ochsner.
5. Mrs. Ben H. Johnson, Jr., Woman's Auxiliary president.
6. Vanderbilt alumni: Drs. J. A. Little, Carl Grote.
7. Dr. John M. Chenault, chairman, Board of Censors.
8. Both sides of table, Board of Censors meeting.



A (for Activities)

1. Two scenes of awards dinner.

2. ALAPAC Directors breakfast.

3. Two scenes ALAPAC luncheon.

4. Two Las Vegas Party scenes.

5. Astronaut Frank Borman receives honorary Huntsville citizenship from Mayor Joe Davis.

6. Audience breathlessly attends trip around the moon.



S (for Speakers)

1. Judge James N. Bloodworth.

2. Astronaut Frank Borman.

3. Green Bay Packers Quarterback Bart Starr.

4. Dr. C. L. Butler, president host society.

5. Huntsville Mayor Joe W. Davis.

6. Dr. Charles Berry, Houston.

7. Dr. James H. Sammons, Highlands, Texas.

8. Dr. Alton Ochsner, New Orleans.

9. Mrs. Richard Dillard, Birmingham, AMA-ERF chairman.

10. Dr. Dwight Wilbur, AMA president.

11. Dr. Grover C. Murchison, Jr., chairman, ALAPAC.



A (for Awards)

1. Dr. W. H. Y. Smith poses at home with his William Henry Sanders Award, which was accepted for him at Huntsville by:

2. John Hill and Dr. Smith's son, Michael.

3. Mr. Barrett Shelton, Sr., with his William Crawford Gorgas Award; Dr. Ira B. Patton, chairman, MASA subcommittee on awards; Dr. Aubrey E. Terry, recipient of the A. H. Robins Community Service Award.

4. Mr. Shelton receives the check that went with his award from Dr. John M. Chenault.

5. Mr. Thomas W. (Wes) Diamond, Mobile, receives the Douglas L. Cannon Medical Reporter Award from Dr. Patton.

Senator Hill And His Contributions To Health Sciences

Special to Journal of the Medical Association of the State of Alabama

The University of Alabama in Birmingham will have on permanent display two symbols of former Senator Lister Hill's long career of service to the health sciences, a bust of the legislator and a collection of his awards.

The bronze likeness of the Alabama senator, created by Italian sculptor Gaulberto Rocchi, was unveiled in late March (March 30) as an event of the Birmingham Festival of Arts.

"We wanted to honor Senator Hill for his contributions to the healing arts and with the Festival saluting Italy and the Healing Arts, it seemed appropriate to have the bust created by an Italian artist and to plan the unveiling as a part of the city's Festival," said Dr. Joseph F. Volker, executive vice president of UAB.

Dr. Volker, along with representatives of the Medical Center and other health organizations who wished to participate in the tribute, awarded the commission to Rocchi. The sculptor was on his way to the United States to attend the inauguration of President Nixon, one of the many personages whose likeness he has captured.

Organizations contributing to the project are the Caduceus Club of the Medical College of Alabama, the Alumni of the School of Dentistry, Alabama Hospital Association, Medical Association of the State of Alabama, Alabama Tuberculosis Association, the Alabama League of Municipalities and the Alabama Mental Health Association.

Senator Hill has also given his collection of plaques and awards to the UAB Medical Center.

The 142 plaques, representing his life of public service, range from citations from the U. S. Department of Health, Education and Welfare to a token of thanks from individuals receiving care in Alabama tuberculosis hospitals and who share the Senator's birth date of December 29.



The Bust and Senator Hill

Among the awards are certificates for almost a dozen honorary degrees of Doctor of Laws and Doctor of Science and honorary membership in many medical and health-oriented organizations.

The UAB Medical Center will be doubly enriched with the permanent remembrances of Senator Hill who has been so important a figure in the growth of the Center from its one original block to the present fifteen square blocks. The majority of buildings on the campus have been built or remodeled with funds obtained through the Hill-Burton Act.

Senator Hill's personal efforts in legislation, particularly the Hill-Burton Act, have enabled the construction or rebuilding of more than 9,000 hospitals. Other health legislation sponsored by the Senator has resulted in aid to medical and dental schools, organization of a health research program, erection of centers for treatment of mental illness and mental retardation, training programs for nurses and paramedical personnel, regional centers for treatment of heart disease, cancer and stroke, as well as additional important health measures.

Alabama is a leader among the states taking advantage of Hill-Burton funding. All but two of the state's 67 counties have hospitals, health centers or other facilities built under the program. According to the Department of Health's bureau of construction, 319 facilities in the state have been completed, are under construction, or have funds allocated for construction.

Senator Hill's bust, along with the collection of plaques and awards, will be placed in the new Medical Center Library, which is now under construction. The L. L. Hill Collection of Medical Books, belonging to Senator Hill's father, is the cornerstone of the Center's medical library.

BUREAU OF PREVENTABLE DISEASES

Frederick S. Wolf, M. D., Acting Director

Current Morbidity Statistics

1969

	Feb.	March	*E. E. March
Tuberculosis	73	103	113
Syphilis	33	28	132
Gonorrhea	433	478	335
Chancroid	0	1	2
Typhoid fever	0	0	0
Salmonella	10	10	2
Undulant fever	0	0	0
Shigella	3	2	3
Amebic dysentery	0	0	4
Scarlet fever & strep. throat	419	654	283
Diphtheria	1	0	1
Whooping cough	1	4	7
Meningitis	7	5	7
Tularemia	0	0	0
Tetanus	0	0	1
Poliomyelitis	0	0	0
Encephalitis	1	0	0
Smallpox	0	0	0
Measles	0	0	369
German measles	33	42	7
Chickenpox	78	94	137
Mumps	39	36	96
Infectious hepatitis	49	41	44
Typhus fever	0	0	0
Malaria	3	1	0
Cancer	378	1,273	647
Pellagra	0	0	0
Rheumatic fever	5	8	17
Rheumatic heart	14	23	25
Influenza	4,600	1,707	1,638
Pneumonia	621	522	348
Rabies—Human cases	0	0	0
Pos. animal heads	1	8	0

As reported by physicians and including deaths not reported as cases.

*E. E.—The estimated expectancy represents the median incidence of the past nine years.

BUREAU OF LABORATORIES

Thomas S. Hosty, Ph. D., Director

Alabama Department of Public Health
Laboratory Combined Division Report for Period

February 1969

	No. Specimens received
General Bacteriology	1,765
Virology	190
Parasitology	1,734
Enteric Bacteriology	206
Fluorescent Microscopy	6,045
Tuberculosis	5,010
Mycology	56
Milk and Dairy Products	5,609
Water	3,273
Sea Foods	101
Syphilis Serology	29,058
Special Serology	1,303
Metabolic Diseases	24,832
Cytology	2,188
Chemistries	158
Miscellaneous	815
Total number of specimens received	82,343

BUREAU OF PREVENTABLE DISEASES

W. H. Y. Smith, M. D., Director

Current Morbidity Statistics

1969

	Jan.	Feb.	*E. E. Feb.
Tuberculosis	101	73	115
Syphilis	52	33	126
Gonorrhea	388	433	288
Chancroid	1	1	2
Typhoid fever	0	0	0
Salmonella	7	10	12
Undulant fever	0	0	0
Shigella	2	3	5
Amebic dysentery	1	0	2
Scarlet fever & strep. throat	445	419	243
Diphtheria	0	1	0
Whooping cough	1	1	4
Meningitis	1	7	6
Tularemia	0	0	0
Tetanus	0	0	1
Poliomyelitis	0	0	0
Encephalitis	0	1	0
Smallpox	0	0	0
Measles	0	0	264
Chickenpox	50	78	124
Mumps	35	39	76
Infectious hepatitis	35	49	48
Typhus fever	0	0	0
Malaria	1	3	0
Cancer	388	378	607
Pellagra	0	0	0
Rheumatic fever	16	5	13
Rheumatic heart	13	14	29
Influenza	42,335	4,600	2,778
Pneumonia	581	621	361
Rabies—Human cases	0	0	0
Pos. animal heads	5	1	0

As reported by physicians and including deaths not reported as cases.

*E. E.—The estimated expectancy represents the median incidence of the past nine years.

Virological Studies

INTRODUCTION

This brochure has been prepared by the Bureau of Laboratories for the purpose of informing private physicians, clinics, and hospitals throughout the state of the services available, without charge, as aids in the specific diagnosis of viral and rickettsial diseases. It will be noted that these services do not include all infections within these categories. This limitation can be attributed to one or more of the following reasons: no completely satisfactory test has been developed for routine application; the infection is not known to occur in or to any signnificant extent in Alabama; the etiologic agent has never been isolated or characterized; or the infection may be of the more exotic type or beyond reason of public health importance.

While the State Bureau of Laboratories in Montgomery is constantly striving to improve established services and to evaluate the reliability of more recently reported methods in the field, situations may arise at times where it would be more advantageous for submitted specimens to be forwarded to the National Communicable Disease Center in Atlanta, Georgia for more detailed study. Through a long standing mutual agreement the forwarding of specimens and the decision to request services of the National Communicable Disease Center rests solely with the Bureau of Laboratories. Physicians and hospitals can avoid unnecessary delays by not attempting to by-pass state channels. The National Communicable Disease Center will not directly accept diagnostic materials or requests from private physicians or institutions within the state.

A rather unfortunate but unavoidable circumstance associated with the laboratory diagnosis of viral and rickettsial diseases is the relatively long period required to complete the definitive tests; often times the patient is well and has returned to normal activity before the results of laboratory requests are returned to the physician. This is especially so in the case of viral isolation studies because of the very nature of these agents and the fact that their obligate intracellular parasitism necessitates the use of highly specialized techniques. In contrast, usually one week is the average time required for most serological determinations.

COLLECTION OF SPECIMENS FOR VIRUS ISOLATION

In general, specifically involved viruses are more likely to be isolated from clinical materials collected within the first few days of the acute, febrile illness. The delivery of these specimens to the laboratory soon after collection is imperative, and they should be kept cold from the time of collection until delivery is made. The recommended method of transportation is to pack the chilled specimens in an insulated cooler in contact with a can of frozen refrigerant. This will keep the specimens cold during shipment by bus or by private conveyance.

A specially designed shipping kit consisting of an insulated box, a can of liquid refrigerant, containers for the collection of specimens and case history forms to accompany them are available from all laboratories upon request.

(Continued on Page 1059)

(Continued from Page 1054)

The chart below may be used as a guide in the collection of specimens.

SPECIMEN	AMOUNT OF MATERIAL	TYPE OF CONTAINER
Stool specimens	5-10 grams per sample	Clean screw-cap jar
Rectal swabs (Preferably, several samples collected on different days)	Should have visible fecal material adhering to swab	Break off swab into screw-cap jar.
Throat swabs	Collect specimen as for bacteriological examination	Break off swab into dry screw-cap tube.
Throat washings (have patient gargle and regargle several times with sterile broth)	10-15 ml sterile broth	Clean screw-cap jar
Whole blood (without preservative)	5-10 ml	Sterile tube or Vacutainer
Spinal or body fluids	2-5 ml.	Sterile tube or Vacutainer
Vesicle fluid	Adsorb fluid onto sterile swab.	Break off swab into sterile screw-cap tube.
Tissue (Biopsy or Autopsy specimens)	Representative aliquots of all affected organs or tissues. *Do not add buffered formalin or any other preservative to these specimens.*	Separate sterile screw-cap jars
Urine	10-20 ml	Clean screw-cap jar.

COLLECTION OF SERA FOR SEROLOGICAL TESTS

A very high percentage of the viral agents infecting man are widely distributed in the population. Many of these agents may produce repeat clinical infection in the same individual or infect without the manifestation of clinical disease (inapparent infection). It is therefore recommended that paired serum specimens be submitted on each patient since only a demonstrative increase in specific antibody titer is definitive evidence of current infection with a particular viral or rickettsial agent. The first serum should be collected as early in the illness as possible and the second from two to three weeks later. In instances where an "early" specimen is not obtainable, it is suggested that the first serum specimen be followed by a second one taken approximately six to eight weeks later. Sometimes a comparison of such late specimens will reveal a decrease in antibody titer which may provide a clue to the agent involved.

It may be noted here that sometimes it is impossible to demonstrate an expected increase in specific antibody in psittacosis, lymphogranuloma venereum, rickettsial, and mycoplasma infections, even though the two serum specimens are collected at appropriate

intervals in the illness. This usually is due to the early administration of effective broad spectrum antibiotics which inhibit replication of the causative agents, thereby limiting the amount of antigenic material available for the stimulation of antibody synthesis.

At least 10 ml of blood (5 ml of serum) should be collected for serological studies to permit a multiplicity of screening tests, confirmation, or re-examination of questionable results when necessary. The serum should be removed from clotted blood and kept under sterile conditions. Care should be taken to avoid hemolysis, since this may interfere with certain tests. No preservative should be added, and serum specimens for serological tests may be shipped without refrigeration in mailing containers provided by the Bureau of Laboratories for this purpose. The kit consists of a brown envelope stamped "VIRUS SEROLOGY" which contains a sterile tube and two copies of the history form.

CASE HISTORY

Each specimen, whether it be for virus isolation studies or serological examination, *must be accompanied by a case history in duplicate* (original and one carbon copy). Case history forms L-266, a sample of which is shown on pages 8 and 9, may be obtained from any branch laboratory or County Health Department, or requested directly from the Bureau of Laboratories in Montgomery. The original copy of the case history form will be filled in by the laboratory when tests are completed and returned to the place of origin; the carbon copy is retained by the laboratory for record purposes.

INTERPRETATION OF LABORATORY RESULTS

It should be emphasized that the laboratory makes no attempt to breach the area of clinical diagnosis. Rather, on the basis of viral isolation studies, serological findings, or both, its role is to indicate whether or not a particular agent is actively present. The physician then can correlate these resuts with clinical and epidemiologic data.

Inability to isolate a specific virus from a specimen does not exclusively eliminate that agent, or an unsuspected one, as the possible cause of the illness in question. The degree to which the infecting agent is disseminated throughout the target tissues, body fluids, etc. at the time specimens are taken and the amount of infectivity remaining in such specimens, are examples of the many factors that must be considered. When a viral agent is isolated, it indicates current infection (which may be inapparent) with that virus. However, it may or may not mean that the agent is responsible for the current clinical manifestations. This question frequently arises when the isolation is made from the respiratory or lower intestinal tracts and the agent is one which is prone to produce widespread inapparent infection in the population. A definitive answer usually is obtainable if paired serum specimens are also available from the patient and a significant increase in antibody to the isolated agent can be demonstrated.

It has been established that most individuals because of previous contact already have antibodies against certain of the more endemic viruses, and the demonstration of specific antibodies in a single serum specimen taken during the course or after a particular illness usually does not definitely prove the etiology of that illness. However, the finding of an increase in antibody titer between paired serum specimens is significant. In certain instances, serologic tests may yield more informative data than virus isolation attempts.

Rabies

EXAMINATIONS FOR RABIES

Animal heads submitted for examination should be severed well beyond the head itself in order that the salivary glands as well as the brain remain intact. In preparing for shipment or conveyance, place the head in a plastic bag or seal in a small can, and place in a larger, water tight container packed with wet ice. Attach by tape or other suitable

BUREAU OF LABORATORIES
ALABAMA DEPARTMENT OF PUBLIC HEALTH
434 Monroe Street; Montgomery, Alobomo 36104

NOTE: THE ORIGINAL AND ONE CARBON COPY OF THIS HISTORY MUST BE SUBMITTED WITH EACH SPECIMEN. SEE REVERSE SIDE FOR FURTHER INFORMATION.

REQUEST FOR VIRAL AND RICKETTSIAL SERVICES

I

Specimen	Date Collected	Kind of Specimen	Laboratory Number
1st			Patient's Name Age Race
2nd			Date of onset of illness

II Epidemiological Data
Animal or insect _____ Family _____ Community outbreak _____ Other _____

III Brief summary of clinical findings: ☐ Fever ☐ Rash ☐ Gastrointestinal ☐ Paralysis ☐ Meningitis ☐ Encephalitis ☐ Fatal ☐ Other:

For Rubella please include: Date of exposure _____ Date rash appeared _____
Is patient pregnant? _____ Trimester _____ (See item 7 on reverse side for instructions.)

IV Complement fixation antigens employed in this laboratory are grouped below. Please check the group indicated by clinical findings. When the report is made by the laboratory, antigens used will be checked or significant titers noted.

RESPIRATORY ☐	TITER 1st	TITER 2nd	NEUROTROPIC ☐	TITER 1st	TITER 2nd	ENTERIC ☐	TITER 1st	TITER 2nd	RICKETTSIAL ☐	TITER 1st	TITER 2nd
Influenza A			Eastern Equine encephalitis			Polio I			Murine Typhus		
Influenza B			Western Equine encephalitis			Polio II			RM Spotted Fever		
Psittacosis–LGV			St. Louis encephalitis			Polio III					
Adenovirus (Group)			California encephalitis								
Mycoplasma pneumaniae			Lymphocytic choriomeningitis								
Respiratory Syncytial			Mumps Saluble								
Parainfluenza 1			Mumps Virol								
Parainfluenza 2			Herpes Simplex								
Parainfluenza 3						EXANTHEMS					
Parainfluenza 4						Rubella ☐					
Q Fever			Reovirus (Group) ☐			Rubeola ☐					

V Comments concerning laboratory findings:

Please type or print name and address of physician or institution below because this space will be used as the mailing label.

Doctor _____

Street _____

City _____ State _____ Zip _____

INSTRUCTIONS

1. The original and one carbon copy of this history must accompany each specimen.

2. The virus group suspected should be clearly checked in the space provided as indicated in section IV on the reverse side.

3. For serological diagnosis, it is recommended that an acute specimen be collected as soon as possible after onset of illness with the convalescent specimen to follow two to three weeks later.

4. If only a convalescent specimen is available, it should be followed by a post convalescent specimen collected two to three weeks later.

5. While serological results on single serum specimens are of limited diagnostic value, they will be reported, and a second serum will be requested. If the second specimen is not received, no additional reminders will be sent.

6. Stool, acute and convalescent serum specimens must be submitted for the diagnosis of Coxsackie and ECHO virus infections. Separate serological tests are not available for these infections because of the many serotypes involved.

7. To determine the immune status of a pregnant woman with exposure to rubella, a single serum collected not later than ONE WEEK after exposure is required.

   To confirm a rubella infection of a pregnant woman, an acute serum obtained within the first three days of rash and a convalescent specimen collected seven to ten days later is necessary.

   Investigation of presumptive complications of rubella (encephalitis, etc.) requires both acute and convalescent specimens.

8. Serological tests for reoviruses are available only when requested on specimens from children under ten years of age.

9. Mailing containers with supplies needed for shipment of specimens are available from laboratories of the State Board of Health. When requesting, please indicate whether they are to be used for shipment of refrigerated specimens for virus isolation or for serum specimens only.

NOTE: FOR FURTHER DETAILS, PLEASE REFER TO THE LOOSE LEAF MANUAL OF THE STATE PUBLIC HEALTH LABORATORY SYSTEM.

means an envelope containing data concerning the case to the outside of the package. This history should indicate the nature of exposure (persons bitten, etc.). In addition, the telephone number of the sender should be included so that the results can be orally reported if the circumstances dictate immediate attention.

Specimens for rabies examination should be delivered in person or by bus to the nearest laboratory. The central and branch laboratories are open during the hours shown on pages one, two and three of this brochure.

When the head is received, the brain and submaxillary glands are removed for study. Each specimen is examined by one or more of the following methods:

1. STAINED SMEARS—Smears are made of critical areas of the brain and stained for microscopic examination for the presence of characteristic inclusion bodies. Since approximately two hours are required for this examination, reports on specimens received after 2-3 PM cannot be made until the following morning.

2. MOUSE INOCULATION—If the history submitted with the brain material or animal head does not definitely state that human exposure has occurred, no mouse inoculation will be made. It is, therefore, imperative that the sender furnish all known information regarding the nature of exposure. Mouse inoculations are made only at the Central Laboratory in Montgomery.

3. FLUORESCENT ANTIBODY TEST—The fluorescent antibody test is highly specific, and the results correlate closely with those obtained with other methods for the detection of rabies virus. Inasmuch as the specimens must be fixed and stained for at least five hours, the results cannot be obtained in less than six hours. As with animal inoculation, this method currently is employed only in the Central Laboratory in Montgomery. It is planned to introduce its use in the Mobile, Birmingham, and Anniston Branch Laboratories as soon as competently trained personnel are available.

MANAGEMENT OF BITING ANIMALS

A dog or cat should be confined and observed for a period of seven to ten days. If the animal dies, the head should be handled as earlier indicated. Because clinical manifestation of rabies in a wild animal sometimes cannot be reliably interpreted, the animal should be killed and the brain immediately examined.

TREATMENT OF THE PATIENT

1. First Aid—The wound s h o u l d be cleaned immediately by flushing with water, soap and water or detergent, such as 1 per cent aqueous solution of Benzalconium chloride (Zephiran) and water.

2. By Physician:

   (a) Thorough, gentle cleansing of the wound with soap solution. Quaternary ammonium compounds may be used after all traces of soap are removed. (Soap neutralizes the activity of these compounds).

   (b) Tetanus prophylaxis and treatment to control bacterial infections.

   (c) Do not suture or close wound.

   (d) If antirabies serum is given, part of the total dose should be thoroughly infiltrated around the wound. A history concerning hypersensitivity to horse serum should be taken and appropriate tests performed.

   (e) The decision concerning vaccination is the physician's responsibility.

Every human exposure to rabies infection must be evaluated on an individual basis. The World Health Organization recommends that the following factors be considered before initiating antirabies treatment.

1. Species of animal involved
   Carnivorous animal (especially skunks, foxes, raccoons, dogs, cats, and coyotes) and bats are more likely to be infective than other animals.
2. Circumstances of the biting incident
   An unprovoked attack is more likely to mean the animal is rabid.
3. Extent and location of wound
   (a) Severe; multiple or deep puncture wounds or bites on the head, face, neck, hands, or fingers.
   (b) Mild: scratches, lacerations, or single bites on other areas of the body as well as abrasions which are suspected of being contaminated with saliva.
4. Vaccination status of the biting animal
   An adult animal immunized properly with rabies vaccine has only a minimal chance of developing rabies.
5. Presence or absence of animal rabies in the area

The following chart correlates the above mentioned factors with methods of specific treatment as recommended in 1967 by the Public Health Service Advisory Committee on Immunization Practices and incorporates the basic concepts of the WHO Expert Com-

(Continued on Page 1066)

Biting Animal		Treatment		
Species	Status at Time of Attack	Exposure		
		No.Lesion	Mild*	Severe *
Dog or Cat	healthy	none	none[1]	S[1]
	signs suggestive of rabies	none	V[2]	S+V[2]
	escaped or unknown	none	V	S+V
	rabid	none	S+V	S+V
Skunk, Fox, Raccoon, Coyote, Bat	Regard as rabid in unprovoked attack	none	S+V	S+V
Other	consider individually			

*V—Rabies Vaccine

S—Antirabies Serum

1—Begin vaccine at first sign of rabies in biting dog or cat during holding period (preferably 7-10 days)

2—Discontinue vaccine if biting dog or cat is healthy 5 days after exposure, or if acceptable laboratory negativity has been demonstrated in animal killed at time of attack. If observed animal dies after 5 days and brain is positive, resume treatment.

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An easy solution to the problem of nasal symptoms of hay fever, colds and sinusitis

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NTZ Nasal Spray affords the well-known benefits of Neo-Synephrine®, 0.5 per cent, the more potent solution (adult strength) in a carefully balanced formula which includes:
Neo-Synephrine (brand of phenylephrine) HCl 0.5 per cent, decongestant
Thenfadil® (brand of thenyldiamine) HCl 0.1 per cent, antihistamine
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Available: NTZ Nasal Spray in squeeze bottles of 20 ml.; NTZ Solution in bottles of 1 oz. with dropper.



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(Continued from Page 1064)

mittee on Rabies. The recommendations are intended only as a guide, and they may be modified according to knowledge of the species of biting animal and circumstances surrounding the biting incident.

POST-EXPOSURE PROPHYLAXIS

1. Active Immunization

   Vaccines (inactivated type):

   (a) Duck Embryo Vaccine prepared from embryonated duck eggs infected with a fixed virus.

   (b) Nervous Tissue Vaccine prepared from rabbit brain infected with a fixed virus.

NOTE: The brain type rabies vaccine is distributed without charge by the state Health Department. Duck Embryo Vaccine is available from the sources listed at the end of this section. Although it is considered by some to be safer to use than the brain vaccine, it is interesting that, from 1951 to the end of 1968, no reports were received of any paralytic reaction from the use of the brain type vaccine in Alabama.

SCHEDULE FOR USE OF VACCINE

Primary Course: At least 14 single, daily injections of vaccine in the dose recommended by the manufacturer should be given subcutaneously in the abdomen, lower back, or lateral aspect of the thighs. Rotation of injection sites is recommended. For severe exposures, 21 doses of vaccine are recommended. These may be given as 21 daily injections or 14 doses during the first 7 days (either two separate injections or a double dose), with the remaining doses given singly during the next 7 days.

Booster immunization: Two booster doses, one 10 days and the other at least 20 days after completion of the primary course. The two booster doses are especially important if antirabies serum was used in the initial treatment.

PRECAUTIONS: Antihistaminic drugs should be used if rabies vaccine must be given to a patient with a history of sensitivity. In reactions of the anaphylactoid type epinephrine is helpful. If serious allergic reactions prevent continuation of treatment with one vaccine, the other type of vaccine may be used. Corticotrophin or corticosteroids are used for meningeal or neuroparalytic complications. If meningeal or neuroparalytic reactions occur, vaccine treatment should be discontinued altogether.

Passive Immunization: Hyperimmune serum has proved effective in preventing rabies. Its use in combination with vaccine is considered the best post-exposure treatment. The only antirabies serum now available is of equine origin. Since at least 20 per cent of those receiving horse serum experience an allergic reaction, its use must be limited.

Hyperimmune serum is recommended for most exposures classified as severe and for all bites by rabid mammalian species. Hyperimmune serum should be used, when indicated, regardless of the interval between exposure and treatment. Although previous instructions were for the use of serum within 72 hours, it is now felt that it should be used immediately or as quickly as possible after the bite occurs.

The recommended dose is 1000 units (1 vial) per 40 pounds of body weight. A portion of the antiserum is used to infiltrate the wound, and the remainder is injected intramuscularly. As noted before, a careful history should be obtained and appropriate tests for hypersensitivity performed.

The following immunization schedule is recommended by the Public Health Service Advisory Committee on Immunization Practices (1967):

Two 1.0 ml injections of Duck Embryo Vaccine subcutaneously in the deltoid area

1 month apart should be followed by a third dose 6 to 7 months after the second date. This series of three injections can be expected to produce neutralizing antibody in 80 to 90 per cent of vaccinees 1 month after the third dose.

If more rapid immunization is desirable, three 1.0 ml injections of Duck Embryo Vaccine may be given at weekly intervals with a fourth dose 3 months later. This schedule elicits an antibody response in about 80 per cent of the vaccinees.

All those receiving the pre-exposure vaccination should have their serums tested for neutralizing antibody 3 to 4 weeks after the last injection. Tests for rabies antibody can be arranged with or through the State Health Department Laboratory. If no antibody is detectable, booster doses should be given until a response is demonstrated. Persons with continuing exposure should receive 1.0 ml booster every 2 to 3 years.

When an immunized individual with previously demonstrated antibody is exposed to rabies, it is suggested that for a mild exposure, one booster dose of vaccine be given, and for a severe exposure, five daily doses of vaccine plus a booster dose 20 days later. If it is not known whether an exposed person has antibody, the complete post-exposure antirabies treatment should be given.

At the time of printing, the following drug outlets have indicated that they usually have a supply of rabies hyperimmune serum and/or Duck Embryo Vaccine available:

McKesson & Robbins Drug Company
492 Theta Avenue
Birmingham, Alabama
Telephone: 251-4171

Walker Drug Company*
2901 2nd Avenue South
Birmingham, Alabama
Telephone: 324-1794

Durr Surgical Supply
2061 West Fairview
Montgomery, Alabama
Telephone: 263-4463

Durr Drug Company
2061 West Fairview
Montgomery, Alabama
Telephone: 265-0511

South Eastern Drug Company*
321 North Lawrence
Montgomery, Alabama
Telephone: 264-8411

McKesson & Robbins Drug Company*
450 St. Louis Street
Mobile, Alabama
Telephone: 432-8751

Durr Drug of Mobile, Inc.
85 Sidney Phillips
Mobile, Alabama
Telephone: 478-6301

Bedsole Surgical Supply Co., Inc.*
1450 Center Street
Mobile, Alabama
Telephone: 438-4686

*Duck Embryo Vaccine only

PRE-EXPOSURE PROPHYLAXIS

Veterinarians, selected laboratory workers, animal handlers, personnel located in areas where rabies is a constant threat, and others who are frequently exposed to dogs, cats, foxes, skunks or bats should be considered for pre-exposure prophylaxis. Since there has been a relatively low reported frequency of reactions to the Duck Embryo Vaccine, its use is currently indicated for pre-exposure immunization of individuals in high risk groups.

The Laryngectomee And Speech Rehabilitation

J. Buckminster Ranney, Ph. D.

The physician, especially the otolaryngologist, has a special concern for the total health of the laryngectomee. One aspect of the total health concern is the return of the laryngectomee to his family and to society. The speech pathologist may assist the otolaryngologist to meet the communicative concern of his patient. A philosophy and a plan to assist the laryngectomee to master esophageal speech is presented.

The examination of materials relating to esophageal speech and esophageal speech training suggests disagreement. Materials prepared for the "teacher" and materials prepared for the "student" may be in disagreement.[2,5] Materials prepared solely for the use of "teachers" may be in disagreement.[1,4] Finally, the materials for "students" may be in disagreement.[2,7] The disagreements noted may not pose problems for the speech pathologist, for he may assume an eclectic point of view, "if it works—use it." However, the laryngectomee is seeking "the way." He may have been given a copy of Doehler[2] or Nelson[5] both of which provide *prescriptive* comfort. The initial meeting between laryngectomee and speech pathologist may be frustrating to the laryngectomee, for the speech pathologist presents a *descriptive* program of training.

The clinical approach for the laryngectomee would be esophageal speaker may be divided for the purposes of convenience into five steps.

1. Pre-Operative
2. Post-Operative
3. Initial Training Program Interview
4. Training Program
5. Terminal Training Program Interview

1. Pre-Operative

The wisdom of the pre-operative consultation for the prospective laryngectomee is accepted. West's observation[8] that there should be three phases is perhaps the most positive. The surgeon in his consultation with the patient may minimize if not allay the death assumption sometimes associated with the "knife." The assurance given to the patient may be especially pertinent with the recognition that cancer of the larynx has the highest incidence in the upper age group of the population.

The speech pathologist in his pre-operative consultation with the patient may indicate the nature of the training program which is planned for the laryngectomee. The concept of the "simple burp" may be explored at this meeting; however, the ability or inability of the patient to imitate the "burp" need not be a matter of concern suggest Hudson and Oswald.[4] The pre-operative use of the films NEW VOICES (Cleveland Hearing and Speech Center) or OESOPHAGEAL SPEECH (British Information Service) is advised by Berry, Van Riper, and West .[1,6,8]

The esophageal speaking laryngectomee in the pre-operative consultation answers best for the patient his important question, "Can I talk again?" The laryngectomee *is* talking. "Can I work again?" Again this question may be answered by the laryngectomee for presumably he *is* working. The role of the laryngectomee is to re-enforce the positive concepts which have been presented by the surgeon and the speech pathologist. Laryngectomees are encouraged to perform this

Speech and Hearing Clinic, Auburn, University.

service by the International Association of Laryngectomees.

2. Post-Operative

The problem of and need for post-operative consultation prior to the initiation of speech training may not have been given sufficient recognition suggests Van Riper.[6] Interviews with laryngectomees suggest that the immediate post-operative period is the point of greatest depression. Fowler Duggar, Sr., a 20 year laryngectomee and leader of a community Lost Chord Club, reports that in the immediate post-operative period he seriously considered suicide—life for him without his speech had no meaning (Duggar/Ranney personal interview). All esophageal patients in the Auburn University Speech and Hearing Clinic appear to have some hesitations and doubts about their personal rehabilitation. The phases of the pre-operative program might again be introduced. The surgeon may observe, "You will live." The speech pathologist may again note, "You will have speech training." The speaking laryngectomee may say, "You will speak again!" The psychological support provided by the statements should assist in the resolution of the post-operative depression experienced by the recent laryngectomee.

3. Initial Training Program Interview

The laryngectomee, the laryngectomee's family, the referral agency, and in some instances other persons all wish to know, "When will he (the laryngectomee) speak again? How long will it take? What should I do?" These questions are legitimate and should be answered by the speech pathologist —a reasonable prognosis should be made. The prognosis made by the speech pathologist should reflect both the practice of the clinic and the considerations suggested by Berry and Eisenson,[1] "Age; motivation; health; freedom from fear, guilt, and shame; learning ability; self-confidence; and faithfulness in practice. . ."

The initial training program interview should be a learning situation for the speech pathologist, not the laryngectomee. The speech pathologist must develop his case history with the assistance of the laryngectomee, his family, and the health records. The speech pathologist should present the essential elements of the training program and review for the laryngectomee the nature of his "new voice"; the Waldrop and Gould[7] concepts of schematic rather than detailed information appear to have merit. The reactions of the family, the attitudes of the laryngectomee, and the case history should provide a basis for a reasonable prognosis.

The materials presented at various symposia (ASHA Annual Conventions) suggest that the practice of individual clinics must be sufficiently flexible to adapt to the needs of a variety of persons. Case demonstrations at the symposia indicated that at least one laryngectomee "learned" effective esophageal speech after one five to ten minute post-operative demonstration of the skill; while another after a period of six months intensive training abandoned esophageal speech in favor of the artificial larynx. A practical course suggested by these extremes of individual difference is that the speech pathologist plan for *each* case a tentative series of meetings based upon the speech pathologist's "reasonable prognosis."

The initial training program interview is an excellent opportunity for the speech pathologist to discuss with the family the role it must play in the process of rehabilitation. The interrelationships of husband-wife and parent-children should be explored (VOGUE and VANITY FAIR, October 1956). Details of clothing should be considered as suggested by Waldrop and Gould.[7] Nelson[4] believes re-orientation to such changed habits as bathing should be understood by the laryngectomee and his family.

At the conclusion of the initial training program interview the speech pathologist should be prepared to present to the laryngectomee, the referral agency, and to the laryngectomee's family an "educated guess"

in answer to the questions of when and how long.

4. Training Program

Berry and Eisenson, Doehler, Nelson, Van Riper and Irwin, Waldrop and Gould, and West, Ansberry and Carr[1,2,5,6,7,8] all divide the training program into steps, lessons, or phases. The elements common to all are: A) first "burp" or vowel like sound; B) first word or words; C) first word series, phrases or simple sentences; D) recorded or telephonic communication. A prerequisite to any of the elements is a degree of rapport between laryngectomee and speech pathologist and the speech pathologist's success in reducing tension and preventing fatigue for the laryngectomee. The speech pathologist's suggestion "to relax" is not sufficient; the total clinical setting must put the laryngectomee at ease.

A) First "burp," the first sound may or may not have been developed in the hospital and at the initial training program interview. The speech pathologist should again review and demonstrate a simple sound. The Auburn University Speech and Hearing Clinic uses fourth, fifth, and sixth grade children to demonstrate the sound. Casual observation of his age group will reveal that most of the males easily and without facial grimaces create esophageal sounds. The laryngectomee should be encouraged to imitate the sound. West's observation[8] "The therapist should not insist upon any particular method but should accept any which does not result in unsightly mannerisms. . ." may be especially pertinent. And, the Waldrop and Gould[7] "obtain the air" may be more helpful than the Doehler[2] "swallow air." The Nelson[5] "tongue thump" may be especially confusing to the uninitiated, and Van Riper and Irwin[6] suggest that the use of the tongue to trap the air may be detrimental to effective articulation. The Doehler[2] belief that the first sound should be "ba"—the initial element a clear bilabial plosive—does not receive support from Nelson[5] or Waldrop and Gould.[7]

The speech pathologist may accept the vowel as the initial element, for the vowel tends to be the first speech concept in the development of language. All the orthographic vowels, a, e, i, o, and u, may be explored at the first "burp" session or sessions. The need to practice for ease of production and maximum resonance should be stressed at this time. West's motation[8] that the beginning practice periods be of short duration and spread throughout the day has merit. Ten minutes practice in each hour for a period of six to eight hours may be of greater learning value than 60 minutes concentration at one time; further ten minute units tend to reduce fatigue and minimize indigestion type problems. When the laryngectomee is able to reproduce "at will" the esophageal sound including the vowels, he has completed the first element.

B) First word, the first word may be the number series 1-10 for Waldrop and Gould;[7] a list of monosyllabic units for Nelson;[5] or as West, Ansberry, and Carr[8] suggest they may be social communicative units, bye, no, etc. Doehler[2] interposes a nonsense syllable step between the vowel elements and the first word. If the speech pathologist assumes that the laryngectomee has essentially an articulation problem the use of the nonsense syllable may be justified. The problem as conceived by the Auburn University Speech and Hearing Clinic is that the laryngectomee can articulate—he lacks communicative practice with the new source of energy for speech; hence the number series is used for it provided the semantic familiar plus vowel and consonant practice. The numbers series is used in conjunction with the social communicative units, especially bye; also the number series is presented in relationship to a telephone number. An attempt is also made during this first word element to develop an approximation of the laryngectomee's mate's first name.

The stress on the elements of communication is deliberate. Every attempt is made to have the laryngectomee discard as soon as

possible all nonoral and not-audible methods of communication, the writing pad for example. Should the concepts of Hudson and Oswald[4] be accepted, whispering is even to be preferred to over-dependence on the writing pad. The speech pathologist must move the laryngectomee beyond the first word stage as soon as is practicable, for West, Ansberry, and Carr[8] believe fixation at this stage will tend to restrict the development of fluent speech. A measure of progress and a method of comparison as suggested by Van Riper and Irwin[6] are to record this stage of speech proficiency for the laryngectomee.

C) First word series, the first word series may be phrases which are used by Doehler;[2] short word combinations as suggested by Nelson;[5] or the more advanced lines of verse presented by Waldrop and Gould.[7] The practice of the Auburn University Speech and Hearing Clinic is to view this first word series as an element in the development of fluent and communicative speech, and the successful mastering of first word series is viewed as a crucial step toward returning the laryngectomee to employment; hence a great effort is made to develop for *each* laryngectomee word series which relate to his social life and to his mode of employment. For example, a bridge player may master "pass, I double, your bid, two no trump, etc." The textile inspector may master "too wide, too narrow, 54 inches." The short-order cook may master "with bacon, cream and sugar, chili with beans." The laryngectomee and the expressive aphasic have much in common—they know the words. They lack the communicative skill.

The use of words as communicative tools rather than words as something to be practiced in a book may partially resolve the adjustment problem suggested by Van Riper and Irwin[6] and in the Post-Operative section of this paper. The use of Doehler, Nelson, and Waldrop and Gould[2,5,7] may provide comfort and motivation for the laryngectomee, but these materials should be interpreted and expanded by the speech pathologist. The speech of the laryngectomee should again be recorded during the first word series stage of learning. The laryngectomee should be encouraged to continually review as Waldrop and Gould[7] suggest.

D) Recorded communication, the taped speech of the laryngectomee or the speech communicated over the telephone is considered to be the final element of learning by Berry and Eisenson.[1] Speech in a non face to face situation does demand greater attention to the elements of rhythm and articulation; hence communication over the telephone may be a worthy ultimate goal. However, the telephone for the laryngectomee may pose a block in the same manner that the telephone poses a block for some stutterers. The practice of the Auburn Speech and Hearing Clinic is to use the telephone as the final step *only* if the laryngectomee prior to surgery used the telephone routinely for his social or professional activities. For the laryngectomees who do not need the telephone for social or professional purposes the final element is a narrative report in a face to face situation. As Van Riper and Irwin[6] suggest a pass or fail in the process of rehabilitation should not be dependent upon speaking skill in a restricted manner of communication, the telephone. Further, for the speech pathologist to insist the laryngectomee use the telephone and experience failure may be self-defeating, for the dormant fears and frustrations for the laryngectomee may be rekindled and interfere with the acquired speech.

The training program presented has been *descriptive* rather than *prescriptive*. The program is designed to be executed by a speech pathologist. There has not been an attempt to say that there should be "x" meetings, or that the laryngectomee should learn "y" words. The assumptions underlying the program is that the laryngectomee knows the "language"—he needs only the "skill."

5. Terminal Training Program Interview

West's observation[8] that the laryngectomee might with profit after his "graduation" join

a Toastmaster's Club is positive. The laryngectomee and the stutterer have at this point much in common. They need to speak to someone other than another laryngectomee, stutterer, or speech pathologist. The laryngectomee needs to talk, talk, talk. The speech pathologist must encourage the laryngectomee to continually enlarge his speaking circle. The speech pathologist finds himself, like the midwife, not longer needed when the laryngectomee is "talking." The speech pathologist should terminate his "talking" relationship with the laryngectomee in the final interview.

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BUREAU OF VITAL STATISTICS
PROVISIONAL BIRTH AND DEATH STATISTICS AND COMPARATIVE DATA

1968

Ralph W. Roberts, M. S., Director

Live Births / Deaths / Causes of Death	Number Recorded			Rates*		
	Prov. 1968	Final 1967	Average 1962-1966	Prov. 1968	Final 1967	Average 1962-1966
Live Births	62,945	64,083	73,161	17.5	18.0	21.3
Deaths	33,053	31,740	31,820	9.2	8.9	9.3
Fetal Deaths	1,270	1,298	1,497	19.8	19.9	20.0
Infant Deaths—						
under one month	1,173	1,155	1,496	18.6	18.0	20.4
under one year	1,670	1,727	2,258	26.5	26.9	30.7
Maternal Deaths	26	40	48	4.0	6.1	6.4
Causes of Death						
Tuberculosis, 001-019	203	233	259	5.6	6.5	7.5
Syphilis, 020-029	38	27	38	1.0	0.8	1.1
Dysentery, 045-048	2	1	9	0.1	**	0.3
Diphtheria, 055	2	5	3	0.1	0.1	0.1
Whooping cough, 056	2	1	3	0.1	**	0.1
Meningococcal infections, 057	14	21	18	0.4	0.6	0.5
Poliomyelitis, 080, 081	+2	+3	4	0.1	0.1	0.1
Measles, 085	1	6	9	**	0.2	0.2
Malignant neoplasms, 140-205	4,717	4,615	4,193	130.9	129.5	121.9
Diabetes mellitus, 260	632	598	497	17.5	16.8	14.4
Pellagra, 281	2	2	3	0.1	0.1	0.1
Vascular lesions of central nervous system, 330-334	4,563	4,207	4,425	126.6	118.1	128.6
Rheumatic fever, 400-402	14	13	18	0.4	0.4	0.5
Diseases of the heart, 410-443	10,953	10,637	10,596	303.9	298.6	308.1
Hypertension with heart disease, 440-443	1,151	1,242	1,500	31.9	34.9	43.7
Diseases of the arteries, 450-456	832	819	745	23.1	23.0	21.7
Influenza, 480-483	133	42	124	3.7	1.2	3.7
Pneumonia, all forms, 490-493	895	793	960	24.8	22.3	27.9
Bronchitis, 500-502	97	77	71	2.7	2.2	2.0
Appendicitis, 550-553	18	22	34	0.5	0.6	1.0
Intestinal obstruction and hernia, 560, 561, 570	142	137	157	3.9	3.8	4.5
Gastro-enteritis and colitis, under 2, 571.0, 764	60	52	109	1.7	1.5	3.2
Cirrhosis of liver, 581	255	246	214	7.1	6.9	6.2
Diseases of pregnancy and childbirth, 640-689	26	40	48	4.0	6.1	6.4
Congenital malformations, 750-759	298	339	377	4.7	5.3	5.1
Immaturity at birth, 774-776	335	329	466	5.3	5.1	6.3
Accidents, total, 800-962	2,476	2,411	2,267	68.7	67.7	65.9
Motor vehicle accidents, 810-835, 960	1,315	1,240	1,113	36.5	34.8	32.3
All other defined causes	4,549	4.443	4,594	126.2	124.7	133.6
Ill-defined and unknown causes, 780-793, 795	1,792	1,621	1,579	49.7	45.5	45.8

*Rates: Birth and death—per 1,000 population
Infant deaths—per 1,000 live births
Fetal deaths—per 1,000 deliveries
Maternal deaths—per 10,000 deliveries
Deaths from specified causes—per 100,000 population

**Less than rate of 0.05

*Late effects

New County Society Presidents





Two 1969 Presidents of County Medical Societies are Dr. Kenneth C. Yohn of Barbour and Dr. William D. Lazenby of Lee. Dr. Yohn practices in Eufaula, Dr. Lazenby in Opelika.

BUREAU OF LABORATORIES

Thomas S. Hosty, Ph. D., Director

March 1969

Alabama Department of Public Health Laboratory Combined* Division Report for Period

General Bacteriology	1,764
Virology	159
Parasitology	1,914
Enteric Bacteriology	265
Fluorescent Microscopy	5,302
Tuberculosis	5,130
Mycology	47
Milk and Dairy Products	5,234
Water	3,005
Sea Foods	60
Syphilis Serology	28,660
Special Serology	1,137
Metabolic Diseases	24,004
Cytology	2,618
Chemistries	249
Miscellaneous	687
Total Number of Specimens Received	80,235

* Dothan's monthly specimens report was not received in time to be included in this report.



The person whose name appears above is a real living person. She has volunteered her name to demonstrate what can happen to people who don't use safety belts.

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Warning: Use of any drug in pregnancy, lactation or in women of child-bearing age requires that the potential benefit of the drug be weighed against its possible hazards to the mother and child. As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

Side Effects: Possible side actions include: tachycardia, palpitation, urinary hesitancy or retention, dry mouth, blurred vision, dilatation of the pupil, increased ocular tension, weakness, nausea, vomiting, headache, dizziness, constipation, drowsiness, and rarely, urticaria and other dermatoses. Infrequently, an elderly patient may experience some degree of mental confusion.

Dosage: For adults: One or two tablespoons of liquid or one or two swallow tablets three times daily; depending on severity.

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antacid
demulcent
topical anesthetic

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Liquid

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aluminum hydroxide—magnesium carbonate
(as co-precipitate), 918 mg.

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Indications: Indicated when anxiety, tension and apprehension are significant components of the clinical profile.
Contraindications: Patients with known hypersensitivity to the drug.
Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.
Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.
Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

JOURNAL of the Medical Association of the State of ALABAMA

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24 JUN 1969

IN THIS ISSUE

Stroke and Occlusive Cerebrovascular Disease, Review and Surgical Results in 265 Cases 1107

An Emergency Air-Ground Transport System for Newborn Infants with Respiratory Distress Syndrome 1112

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JUNE 1969



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Before prescribing, see complete prescribing information in SK&F literature or *PDR*.
Contraindications: Hyperexcitability, undue restlessness, hyperthyroidism, porphyria; in patients on MAO inhibitors.
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Adverse Reactions: Overstimulation, restlessness, insomnia, g.i. disturbances, diarrhea, palpitation, tachycardia, elevated blood pressure, tremor, sweating, impotence and headache.
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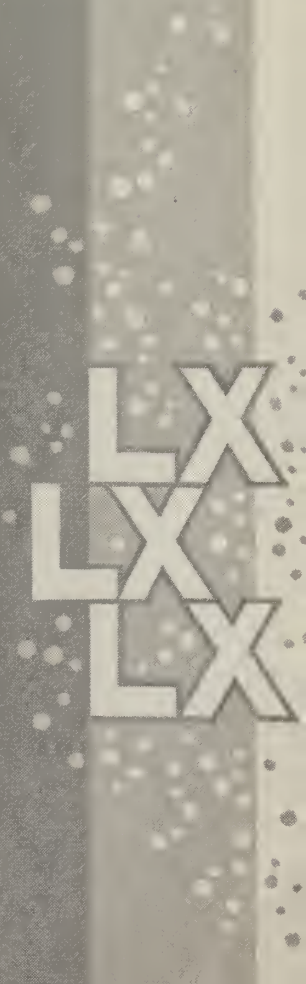
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Literature on indications and dosage available on request.

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References:
(1) Siver, R. H.: CMD, *21*:109, September 1954. (2) Frykman, H. H.: Minn. Med., *38*:19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., *51*:16-18, January 1955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., *15*:15-16, October 1965. (5) Weekes, D. J.: N.Y. State Jour. Med., *58*:2672-2673, August 1958. (6) Weekes, D. J.: EENT Digest, *25*:47-59, December 1963. (7) Abbott, P. L.: Jour. Oral Surg., Anes., & Hosp. Dental Serv., 310-312, July 1961. (8) Rapoport, L. and Levine, W. I.: Oral Surg., Oral Med. & Oral Path., *20*:591-593, November 1965.

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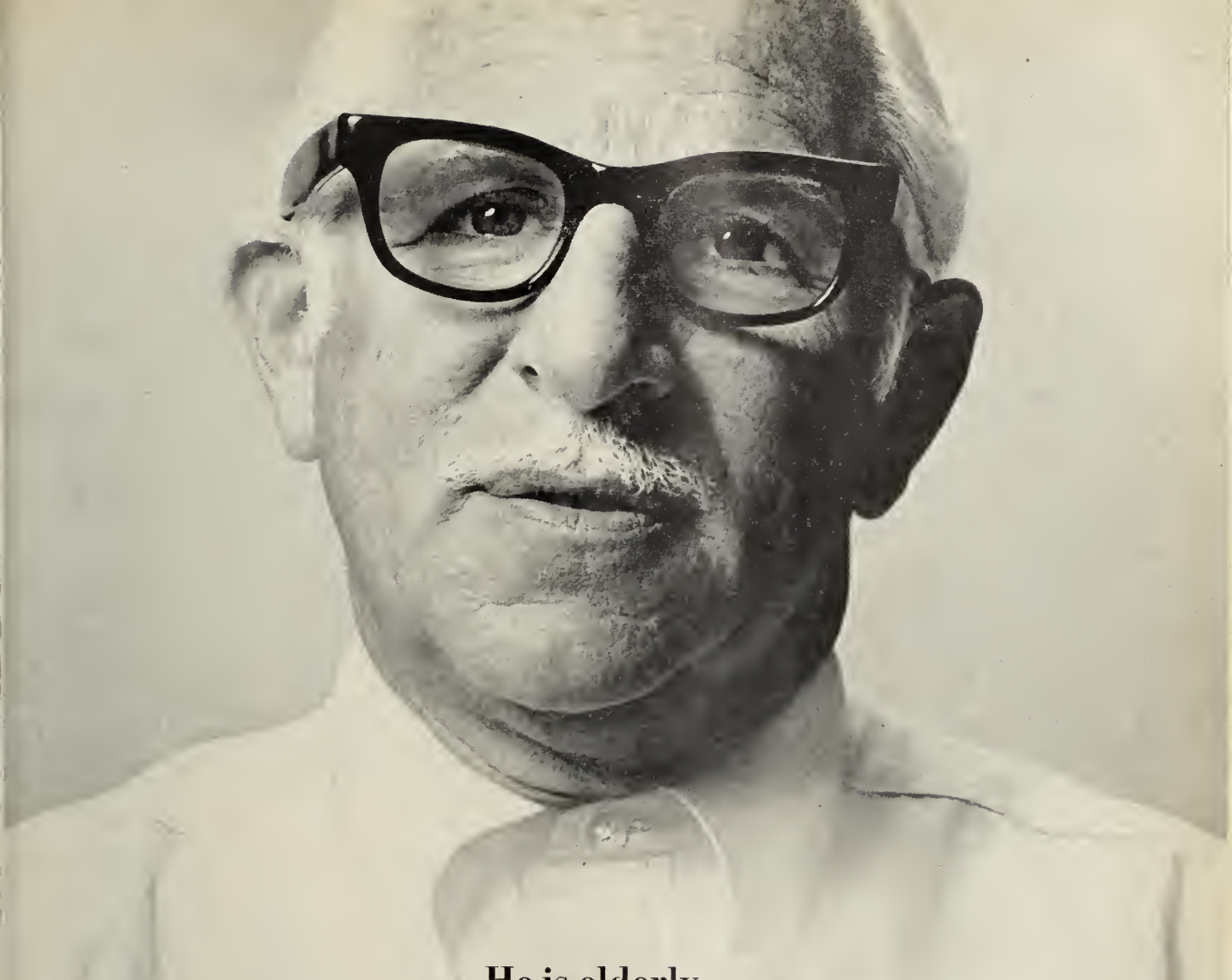
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He is elderly,
he is on corticosteroids,
when he needs an antibiotic
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o guard susceptible patients against intestinal monilial overrowth during broad-spectrum therapy—the protection of ystatin is combined with demethylchlortetracycline in)ECLOSTATIN.

For your susceptible candidates, prescribe DECLOSTATIN the broad-spectrum therapy that prevents monilial vergrowth.

ontraindication: History of hypersensitivity to demethylchlortetracycline or nystatin.

'arning: In renal impairment, usual doses may lead to excessive accumuition and liver toxicity. Under such conditions, lower than usual doses re indicated, and, if therapy is prolonged, serum level determinations ıay be advisable. A photodynamic reaction to natural or artificial sunght has been observed. Small amounts of drug and short exposure may roduce an exaggerated sunburn reaction which may range from erytema to severe skin manifestations. In a smaller proportion, photollergic reactions have been reported. Patients should avoid direct xposure to sunlight and discontinue drug at the first evidence of skin iscomfort. Necessary subsequent courses of treatment with tetracyines should be carefully observed.

recautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken.

In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

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President's Page



C. Kermit Pitt

Again I take the opportunity to express appreciation for the honor of serving as President of the Medical Association of the State of Alabama for the year 1969-70, pledge my devotion and energy to the promotion of the Association's welfare, and congratulate Dr. E. L. McCafferty, Jr., for the completion of a splendid year of accomplishment. I am grateful for his many courtesies and his helpfulness to me during the past year and will expect to benefit from his counsel in the present one. For their interest in preparing me for my administration I am indebted to other people too numerous to name.

I extend congratulations to those members of the Association who attended the 108th Annual Session in Huntsville; and regrets to those who were unable to be present. The hospitality of the Madison County Medical Society and the people of Huntsville was superb. Social events, including Alumni meetings, and Thursday Night Las Vegas party were delightful and enjoyed by many members and their ladies. The Awards banquet on Friday evening was attended to capacity and Bart Starr's address entertaining and stimulating. The Friday ALAPAC luncheon throng was informed and motivated by James H. Sammons, M. D., of Highlands, Texas. AMA President Dwight Wilbur's address on Friday afternoon was forcefully inspiring and gave assurance of aggressive and enlightened AMA leadership.

I am particularly obligated to the people who made the Thursday morning orientation program, "Medicine Meets the Challenge of a Changing World," so interesting and successful. In addition to the new members who were present for orientation, the auditorium was filled with other association members who responded warmly and appreciatively to addresses by John M. Chenault, Chairman, Board of Censors; Thomas H. Alpin, Director of Medical Services, State Department of Public Health; and Judge James N. Bloodworth, Associate Justice Alabama Supreme Court. This session was also blessed by what had to be the highlight of the Annual Meeting, the address by Colonel Frank Borman, Commander of the world's first lunar space craft, whose address was almost unbelieveably delightful.

Friday's scientific sessions on space flight medicine were highlighted by Dr. Wernher Von Braun, Director NASA, Huntsville; Charles A. Berry, Director Research and Operations, NASA, Houston; Physician-Engineer Interaction for Patient Care featuring Dr. Richard B. Sheppard, Mr. Lewis C. Sheppard; and Dr. Harold T. Dodge of the University of Alabama Medical Center, Birmingham, were attended by capacity and appreciative crowds.

Dr. Alton Ochsner's Jerome Cochran lec-

(Continued on Page 1081)

the inside story of a new antacid formulation...

with consistent buffering you can measure



consistently scored high in degree and duration of intragastric buffering

Employing aspiration of gastric juice, indwelling electrode, and/or Heidelberg telemetering capsule techniques,* studies involving 79 subjects with or without proven peptic ulcer disease compared intragastric buffering capacity of Gelusil-M and 1 or the other or both of 2 leading ethical antacids, using comparable doses.*

All three antacids raised the pH above 3.5, an accepted criterion for antacids. The amount of time above this pH helps to characterize the buffering activity of an antacid. While it is not implied that a direct therapeutic correlation exists, these techniques do, however, objectively demonstrate the buffering characteristics of this new antacid in terms of onset of action, peak pH, duration of buffering action.

Mean peak pH*

Gelusil-M, mean peak pH 6.6 (range: 5.6-7.8).
Antacid A, mean peak pH 5.5 (range: 4.2-7.5).
Antacid B, mean peak pH 5.5 (range: 4.4-6.3).

Mean duration of buffering action above pH 3.5*

Gelusil-M, 29.8 mean minutes (range: 18.0-51.8 minutes).
Antacid A, 24.6 mean minutes (range: 6.3-48.0 minutes).
Antacid B, 23.3 mean minutes (range: 5.9-50.0 minutes).

Mean duration of buffering action above pH 5.0*

Gelusil-M, 23.2 mean minutes (range: 14.3-43.9 minutes).
Antacid A, 10.1 mean minutes (range: 6.7-12.2 minutes).
Antacid B, 16.3 mean minutes (range: 8.0-24.2 minutes).

Onset of action*

In speed of intragastric buffering action, Gelusil-M, Antacid A, and Antacid B were consistently rapid and not measurably different.

*References: Antacid studies, data on file, Worner-Chilcott Laboratories Division.

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a consistent buffering anticostive† antacid

† Avoids constipation.

See next page for prescribing information ►

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Gelusil®-M Liquid

Indications: Gelusil-M is indicated for prompt and dependable symptomatic relief of peptic ulcer, gastritis, heartburn, hiatal hernia, esophagitis, and other conditions for which control of gastric hyperacidity is required.

Precaution: Prolonged or intensive therapy in patients with severe renal insufficiency may lead to hypermagnesemia.

Dosage: One to two teaspoonfuls (5 ml. to 10 ml.) between meals and at bedtime or whenever symptoms occur. Certain conditions, such as acute peptic ulcer, may require individualized dosage. If diarrhea occurs, reduce dosage or discontinue use.

Supplied: Gelusil-M (spearmint-flavored)—light green bottles of 12 fl. oz.; and a **special hospital pack.** Keep tightly closed—shake vigorously.

Gelusil® Tablets

Easy to take along / easy to take / pleasantly mint-flavored. An antacid with adsorbent and demulcent properties which contains in one tablet: 0.25 Gm. aluminum hydroxide (Warner-Chilcott) and 0.5 Gm. magnesium trisilicate (USP).

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Regular Gelusil® Liquid

Pleasant mint flavor...ideal for hospital or home. Available in 12 fl. oz. and 6 fl. oz. bottles and a special hospital pack. An antacid which contains adsorbent and demulcent agents in each 4 ml. teaspoonful: 0.25 Gm. aluminum hydroxide (Warner-Chilcott), 0.5 Gm. magnesium trisilicate (USP).

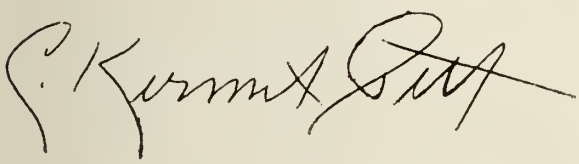
Dosage: 2 teaspoonfuls (4 ml. each)—or more—between meals and at bedtime, or whenever symptoms occur.

Also Available: Gelusil® Flavor-Pack, Gelusil-Lac®.

WARNER-CHILCOTT
Morris Plains, New Jersey
GM-IN-93-4C

(Continued from Page 1078)

ture titled "The Increasing Menace of Communism in the United States" was unusual for meetings of this character but was delivered with Dr. Ochsner's usual scholarly and thought-provoking style. Those of us who were associated with Dr. Ochsner as students in the 1930's who may be inclined toward skepticism about the seriousness of his communistic concern may be tempered by our rememberance of his aggressive but lonely efforts to educate us and the rest of the world as to the evils of cigarette smoking. We could do well to heed his words once again.



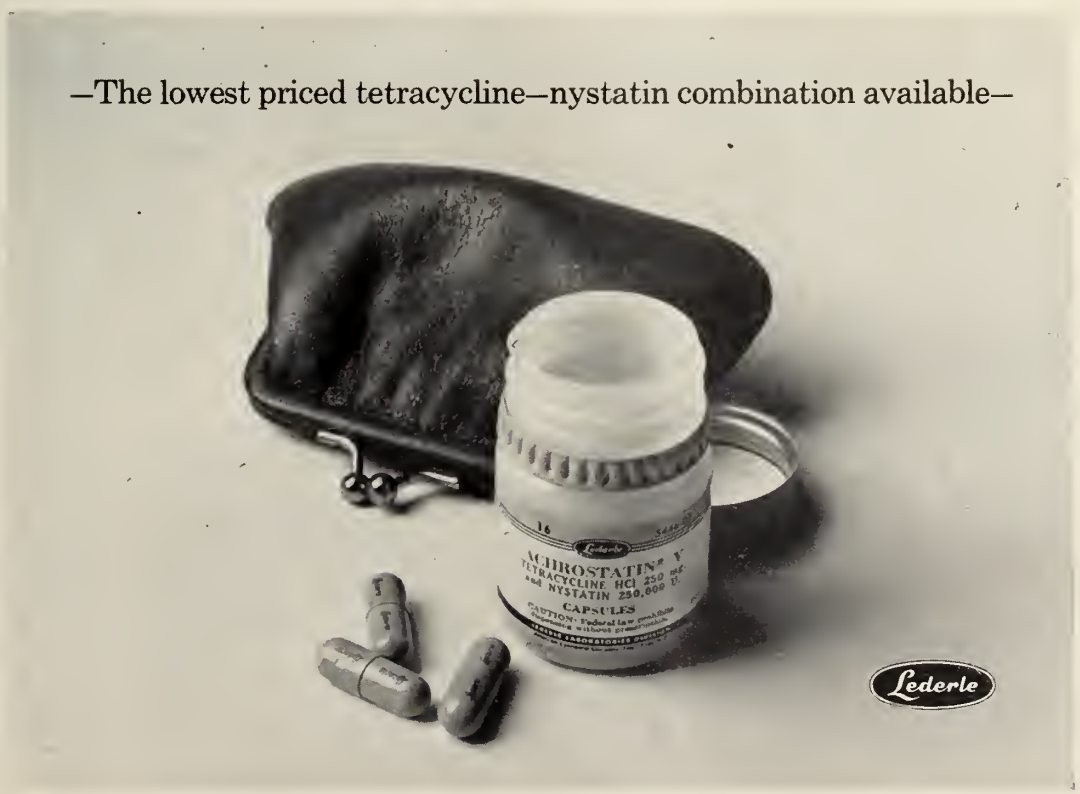
C. Kermit Pitt, M. D.

A Need For Medical Books

The only physician-staffed civilian hospital in a Mekong Delta area of Vietnam, serving a population of more than 400,000 in 300 beds, boasts a "library" without a book in it. The Air Force Medical team assigned to it, in a letter addressed to the Executive Director, Medical Association of the State of Alabama, appeals to Alabama doctors to help. Packages of books and periodicals should be addressed to:

MILPHAP Senior Advisor
553 Medical Service Flight
Advisory Team 72
APO San Francisco 96314

The appeal was signed by Stephen M. Paley, USAF, MC, who stated that the four Vietnamese physicians working there live in a medically isolated community, that medical communication and publications are almost non-existent, that many of the ideas and techniques at the hospital date from the days of the French occupation, and that "English is read and spoken here."



The Woman's Auxiliary

President, Mrs. Ben H. Johnson, Jr.
President-Elect, Mrs. Howard C. Johnson
Northeast District Vice President, Mrs. James D. Holliman, Jr.
Northwest District Vice President, Mrs. Gene Qualls
Southeast District Vice President, Mrs. George Andrews
Southwest District Vice President, Mrs. Andrew D. Henderson
WAMASA Editor, Mrs. William L. Smith

AUXILIARY PLEDGE

"I pledge my loyalty and devotion to the Woman's Auxiliary to the American Medical Association. I will support its activities, protect its reputation and ever sustain its high ideals."

The Convention in Huntsville was a memorable one. Many thanks to the Madison County Medical Society for a great time. The "Las Vegas" party was very enjoyable and the prizes fantastic, congratulations to the lucky ones walking away with silver punch bowls, radios, portable TV's etc. The ALAPAC luncheon was another event shared with the Auxiliary members. This was inspiring and made me look forward to the AMPAC meeting in Washington, D. C. in May. The "Awards Dinner" was, of course, a tremendous success. Thank you for including the Auxiliary on the program for it was with great pride that Mrs. Richard Dillard, our AMA-ERF Chairman presented the check for $14,225.87 to Dr. Clifton K. Meador, Dean of the Medical College of Alabama. We are grateful for the opportunity to again "tell our story of AMA-ERF." And your dinner speaker, Bart Starr, was the frosting on the cake. To be able to hear this football "great" was a real treat, and as I stood in line while he patiently and graciously autographed dozens of pictures, the comments on the evening were a tribute to your planning committee.



Mrs. Ben H. Johnson

I was also privileged to attend your business session on Saturday morning and I was impressed with the meeting. The film "Changing Patterns" presented by Dr. Myers of the State Health Department was very informative and I know would be of great interest to our Auxiliary members. I have made inquiries and would like to use it at our District Workshops in the Fall.

However, I was greatly disturbed to read in a report that $6,683.73 was sent direct to AMA-ERF in Chicago by Alabama physicians in 1968 and this large amount lost to the Auxiliary Fund. Since there is not a committee on AMA-ERF in your Medical Association and you do not have a quota to meet, please send your funds through the Auxiliary and make out your check to *AMA-ERF Auxiliary Fund,* designate the Medical School of your choice and send the check to

Mrs. Richard A. Dillard
3631 Locksley Drive
Birmingham 35223

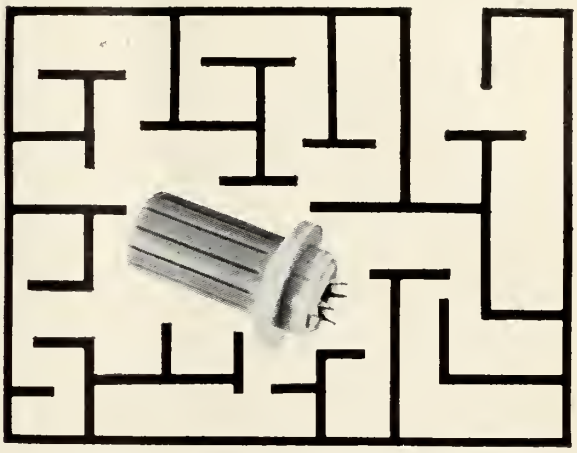
This would give our fund a tremendous boost and would put us over $20,000 which would be an all time high for a state with our membership. Won't you please consider this when you get the statement in your mail from Chicago? We want you to think of AMA-ERF as synonymous with the Auxi-

liary. We really need your help, also, on Membership for there is such a gap between the number of doctors in the Medical Association, 2,470, and the number of members in the Auxiliary, 1,405. Mrs. Howard C. Johnson, President-Elect and Membership Chairman is going to work especially hard on overcoming this in the coming year. Please urge your wife to join with us in our efforts to help you, not only for better health in Alabama, but for better public relations. The doctor's wife is a reflection of her doctor husband, though I must say as I saw the glamorous wives at the functions of the Convention, better packaged.

Ruth L. Johnson

(Mrs. Ben H. Johnson, Jr.)

President, WAMASA



HISTO IS CONFUSING.

Histoplasmosis can mimic such unrelated diseases as TB, leukemia, pneumonia and syphilis. Use the blue Histoplasmin LEDERTINE™ Applicator as the first step in differential diagnosis and as a routine step in physical examinations for the permanent records of your patients.

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Precautions—Nonspecific reactions are rare, but may occur. Vesiculation, ulceration or necrosis may occur at test site in highly sensitive persons. The test should be used with caution in patients known to be allergic to acacia, or to thimerosal (or other mercurial compounds).

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Complete facilities for evaluation and intensive treatment of psychiatric patients, including individual psychotherapy, group therapy, psychodrama, electro-convulsive therapy, Indoklon convulsive therapy, drugs, social service work with families, family therapy, and an extensive and well organized activities program, including occupational therapy, art therapy, athletic activities and games, recreational activities and outings. The treatment program of each patient is carefully supervised in order that the therapeutic needs of each patient may be realized.

High school facilities for a limited number of appropriate patients are now available on grounds. The School Program is fully integrated into the hospital treatment program and is accredited through the Asheville School System.

Complete modern facilities with 85 acres of landscaped and wooded grounds in the City of Asheville.

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Editorial COMMENT

Are You Afraid You Can't Quit Smoking?

"How to Help Your Patient Stop Smoking" is the promising caption on the lead article in the April issue of *Bulletin*, official publication of the National Tuberculosis and Respiratory Disease Association, written by Donald T. Frederickson, M. D.

The illustration is effective, showing a dozen cigarets stubbed out in the sand of a floor container, such as are to be found beside the elevator of almost any floor of any public building in the nation.

"O. K., Doctor, I believe what you say about smoking. Now, how do I go about quitting?" is the challenging first paragraph of the piece, and interestingly it pushes emphysema ahead of lung cancer as the more understandable indictment: "If you quit smoking now, you will lower the odds against having to live with a debilitating chronic respiratory disease for 15 or 20 years later on."

Like alcoholism, cigaret addiction must be conquered by the individual himself. Neither medication nor another's will can do it.

The *Bulletin* approaches the psychological addiction, which as "a habit is nothing more or less than a form of *learned* behavior. So, if one can learn to be a smoker, one can reverse the process and learn to be a nonsmoker."

But the first step, as this article and every other recognizes, is the individual's resolve:

"Health is the most compelling reason to stop but is by no means the only reason. Some people stop because they are annoyed at having lost control of their smoking.



Others will stop not for themselves but for their family or as a positive influence for their children. Others stop for esthetic reasons—they consider the habit dirty or otherwise personally offensive. For some, the economics of smoking may have significance —a 30-year habit at 5 per cent compound interest adds up! And there are those who will stop in response to a challenge—they will stop on a bet! The physician should be sensitive to these different incentives and appreciate that what motivates one smoker may not work for another."

The author of this article prescribes the keeping of a smoking record:—the time of day, the momentary occupation, the mood or

(Continued on Page 1086)

Design for an ear anti-infective

Designed to act promptly against bacterial pathogens and pain

Otitis media (when the tympanic membrane is perforated) and otitis externa both respond to the bactericidal action of Furacin® (nitrofurazone) in Furacin-HC (nitrofurazone-hydrocortisone) Otic. Its broad antibacterial spectrum includes most of the organisms encountered in surface infections (but only certain strains of Pseudomonas). The hydrocortisone component in Furacin-HC Otic affords rapid relief of painful swelling.

Designed to let the ear drain freely

The water-soluble base of Furacin-HC Otic permits free drainage and provides a hygroscopic vehicle.

Designed to please and protect the patient

Topical Furacin-HC Otic lets you reserve systemic preparations for systemic infections. It rarely irritates inflamed epithelial surfaces, and cross resistance or cross sensitization with antibiotics does not occur. In addition, nonmacerating, odorless Furacin-HC Otic softens wax to facilitate removal of cerumen.

Also available: Furocin® Otic (nitrofurozane with nifuroxime and diperadan HCl). The wide antibacteriol range of Furocin is augmented by the antimycotic activity af Micofur® (nifuroxime). Diperodon hydrochloride, an efficient local anesthetic, promptly subdues pain and itching. Indicated in bacteriol otitis externo, atomycasis or bacteriol otitis medio (when the eardrum is perforated).

Precautions: Sensitization ta nitrofurazone may occur with pralonged use and is more likely to develop in eczematous otitis externo. To minimize such reactions (a) limit application to a week ar less, and (b) avoid use of excessive amounts which may run down the face.

This preparation is not indicated for use in treatment of cholesteatoma, where surgical intervention is necessary.

Contraindications: The usual cantraindications for preparations containing hydrocortisone should be observed, such as tuberculous lesions of skin ar ear, acute herpes simplex, vaccinia and varicella, superficial fungus and yeast infections.

Formula: Furacin®-HC Otic contains 0.2% Furacin, brand af nitrofurazone, and 1.0% hydrocortisone acetate in a water-soluble hygroscopic base of glycerin and polyethylene glycol.

Furacin® Otic contains 0.2% Furacin, brand of nitrafurazane, 0.375% Micofur®, brand of nifuroxime, and 2% diperodon hydrochloride dissolved in water-soluble, nondrying, hygroscopic polyethylene glycol.

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NORWICH, NEW YORK 13815

Furacin®-HC Otic
nitrofurazone/hydrocortisone

Furacin® Otic
nitrofurazone with nifuroxime and diperodon HCl



(Continued from Page 1084)

feeling while smoking (bored, angry, tense, nervous), and an assigned value to each cigaret.

The attitude of the would-be nonsmoker is all important. If withdrawal is looked upon as a plus, as a building of self-mastery, quitting can be an exciting experience.

If, on the other hand, one has tried before and failed, fear of another defeat may make one hesitate to try again.

For these, one may recommend the psychological key of Alcoholics Anonymous: Don't quit! Resolve *not* to smoke today. And, surprisingly, tomorrow never comes!

It works.

The Hippocratic Oath Failed To Foresee Preventive Medicine

The modern doctor goes beyond the Hippocratic Oath.

The ancient, respected pledge, to which every graduate M. D. swears, limits itself to the treatment of the sick, except for an indirect proscription on euthanasia: "To none will I give a deadly drug even if solicited."

Hippocrates did not forsee the day when preventive medicine would, through public-health service, become a commitment of every responsible M. D.

With this thought in mind, every practicing physician in the nation should be aware of resolutions adopted by the Board of Chancellors and Council of the American College of Radiology, the text of which follows:

"WHEREAS, after serious and extended investigation many scientific and medical groups have concluded that the practice of chiropractic constitutes a dubious benefit to patients who seek health care; and

"WHEREAS, in the opinion of The American College of Radiology, chiropractic training does not adequately cover the use of ionizing radiation for detecting disease and injury; and

"WHEREAS, the individuals who complete such inadequate training are unable to provide health benefits to patients because of their inability to achieve a differential diagnosis involving adequate interpretation of evidence in X-ray films; and

"WHEREAS, there are inherent dangers to the patient and operator involved in the use of apparatus producing ionizing radiation particularly if the operator is insufficiently trained and has inadequate knowledge of safe practices; and

"WHEREAS, a practice espoused in some chiropractic texts of making X-ray exposures prior to any other consideration of a patient's problem is contrary to the established fundamentals of good radiation safety and sound medical practice;

"THEREFORE, BE IT RESOLVED, that the members of The American College of Radiology advise the people of the United States that they regard the use of radiation by chiropractors as unwarranted and without likelihood of significant medical gain; and

"BE IT FURTHER RESOLVED, that The American College of Radiology requests federal and state health agencies to inform the public of the views of the College in regard to use of X-rays on patients by chiropractors."

(Continued on Page 1088)



In Gastritis

Also available as Estomul Tablets:

Each swallow tablet contains: orphenadrine hydrochloride, 25 mg.; bismuth aluminate, 25 mg.; magnesium oxide, 45 mg.; aluminum hydroxide-magnesium carbonate (as co-precipitate), 500 mg.

Indications: Peptic ulcer: duodenal, marginal, gastric, esophageal; gastroesophageal reflux; esophagitis (without stricture); irritable bowel syndrome; hyperacidity and dyspepsia; congenital shortening of esophagus with esophagitis; heartburn; spasm of the cardiac end of esophagus; gastritis; symptomatic hiatus hernia; alcoholic gastritis; functional pylorospasm.

Contraindications: Because of the anticholinergic action of orphenadrine, Estomul should not be used in patients with glaucoma, pyloric or duodenal obstruction, stenosing peptic ulcers, prostatic hypertrophy or obstruction at the bladder neck, achalasia (megaesophagus), and myasthenia gravis.

Precautions: Doses in excess of six tablets or six tablespoons of liquid daily may produce minor side actions such as dryness of the mouth or blurred vision.

Warning: Use of any drug in pregnancy, lactation or in women of child-bearing age requires that the potential benefit of the drug be weighed against its possible hazards to the mother and child. As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

Side Effects: Possible side actions include: tachycardia, palpitation, urinary hesitancy or retention, dry mouth, blurred vision, dilatation of the pupil, increased ocular tension, weakness, nausea, vomiting, headache, dizziness, constipation, drowsiness, and rarely, urticaria and other dermatoses. Infrequently, an elderly patient may experience some degree of mental confusion.

Dosage: For adults: One or two tablespoons of liquid or one or two swallow tablets three times daily; depending on severity.

Availability: On Rx only. 12 oz. bottles of liquid and bottles of 100 swallow tablets.

anticholinergic
antacid
demulcent
topical anesthetic

it's all here!

Estomul®
Liquid

Each tablespoon (15 cc.) contains:
orphenadrine HCl, 25 mg.;
bismuth aluminate, 50 mg.;
aluminum hydroxide—magnesium carbonate
(as co-precipitate), 918 mg.

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The Riker Representatives in your area are: Bob Johnson, Bill Phillips, Bill Crabb

(Continued from Page 1086)

Our Ailing Health Facilities May Need A Few M. D.s

"Health care in the United States is thought by many to be approaching a crisis in which patients will receive less personal attention, despite massively increased costs," reads a publicity release from the Department of Commerce's National Bureau of Standards. Then it adds piously:

"This concern is reflected in the reports of two Presidential Advisory Commissions, one on manpower and one on facilities for health services for our growing population. We must improve the system in ways other than building facilities and hiring more people, just to keep health care at its present level."

It takes no Presidential Advisory Commissions to tell any awake American that this is a fact. But it will take more than a powerful reading glass to find in the reams of publicity releases out of Washington a single "M. D." after the names composing those advisory commissions, planning bureaus, or—and never overlook this!—the Department of Health, Education and Welfare.

One supposes it is not simply in the cause of *brevity* that the only MD to be found in the list of 350 names carried by the Congressional Directory in the pages devoted to H. E. W. is the abbreviation for Maryland.

There are some "doctors" listed in special divisions of H. E. W. But in view of the fact that even the Surgeon General of the United States carries neither the "Dr." before his name nor the "M. D." after it, one wonders if the "Dr." before the names of some in the H. E. W. roster isn't for Ph. D. or D. D. or even Chir. Doct.

The qualification—"thought by many to be"—in the opening sentence of this editorial, is a waste of space, as every M. D. in the nation realizes. Health care in the United United States *is* approaching a crisis.

The concern of every medical association in the nation—the special business of AMPAC in the United States, of ALAPAC in Alabama, and of every one of the 49 other PAC organizations—is that qualified M. D.'s will be at the bedside of Health Care when it reaches that crisis.

Let's make *need*—rather than *greed*—the determining factor in health care in our country.

Who's Afraid Of The Big Bad Word—Involvement?

"Fear of involvement" and "moral cowardice" are two labels for the same thing.

Under either tag, *responsible* college faculty and students may be indicted for the success of the activists; *loyal* Americans, in and out of Congress, for many American graves in Korea and Vietnam; and the great *majorities* of licensed physicians for the chains being forged around free medical practice in Washington and in the Capitals of the several States.

"Fear of involvement" or "moral cowardice" or call-it-what-you-will is why this nation is in the fix it is today. It is why we accept without question the dictum that "this is a nation of laws, not men," without wondering where are the laws of yesterday, and where are the laws of today coming from.

It was this fear of involvement, this moral cowardice that permitted Lenin to take over in Russia after his betters had overthrown a ruthless autocratic monarchy, that made Hitler and World War II inevitable, that destroyed Chiang Kai-shek and so doomed to

(Continued on Page 1094)

this ulcer did not heal...until its surface was cleared of dead tissue and debris



FIRST APPLICATION
ELASE Ointment is applied to a deep ulceration of a finger.

EIGHTEEN DAYS LATER
Healing has progressed rapidly without interruption or interference from any accumulated purulence or necrotic tissue. Greatly reduced size of lesion and minimal scar tissue indicate quality and vigor of healing which is almost complete.



to aid in debridement to facilitate healing in chronic cutaneous ulcers...

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(fibrinolysin and desoxyribonuclease, combined, [bovine] ointment)

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By helping to remove dead tissue and debris from the ulcer's surface, ELASE Ointment creates a better environment for the elimination of infection, for healthy granulation...*for healing.* Its lytic enzymes effectively break down DNA in dead leukocytes and other debris...the fibrin in blood clots, serum, and purulent exudates...and the denatured proteins in necrotic tissue. Protein elements of *living* tissue are relatively unaffected. ELASE Ointment is indicated in stasis ulcers and in other infected or inflamed ulcers caused by circulatory disturbances. In cases requiring skin grafting, it is used preoperatively for debridement. For ambulatory patients debridement with ELASE Ointment is a convenient therapy and a regimen likely to be followed. *Precautions:* Observe usual precautions against allergic reactions, particularly in persons with a history of sensitivity to materials of bovine origin or to mercury compounds. *Adverse Reactions:* Side effects attributable to the enzymes have not been a problem at the dose and for the indications recommended. *Discussion:* Successful use of enzymatic debridement depends on several factors: (1) dense, dry eschar, if present, should be removed surgically before enzymatic debridement is attempted; (2) the enzyme must be in constant contact with the substrate; (3) accumulated necrotic debris must be periodically removed; (4) the enzyme must be replenished at least once daily; and (5) secondary closure or skin grafting must be employed as soon as possible after optimal debridement has been attained. It is further essential that wound-dressing techniques be performed carefully under aseptic conditions and that appropriate systemically acting antibiotics be administered concomitantly if, in the opinion of the physician, they are indicated. *Available:* ELASE Ointment is supplied in 30-Gm. tubes containing 30 units (Loomis) of fibrinolysin and 20,000 units of desoxyribonuclease with 0.12 mg. thimerosal (mercury derivative); and in 10-Gm. tubes containing 10 units of fibrinolysin and 6,666 units of desoxyribonuclease with 0.04 mg. thimerosal. ELASE Ointment has a special base of liquid petrolatum and polyethylene; contains sodium chloride and sucrose used during manufacture; is stable at room temperature through the expiration date stated on the package.

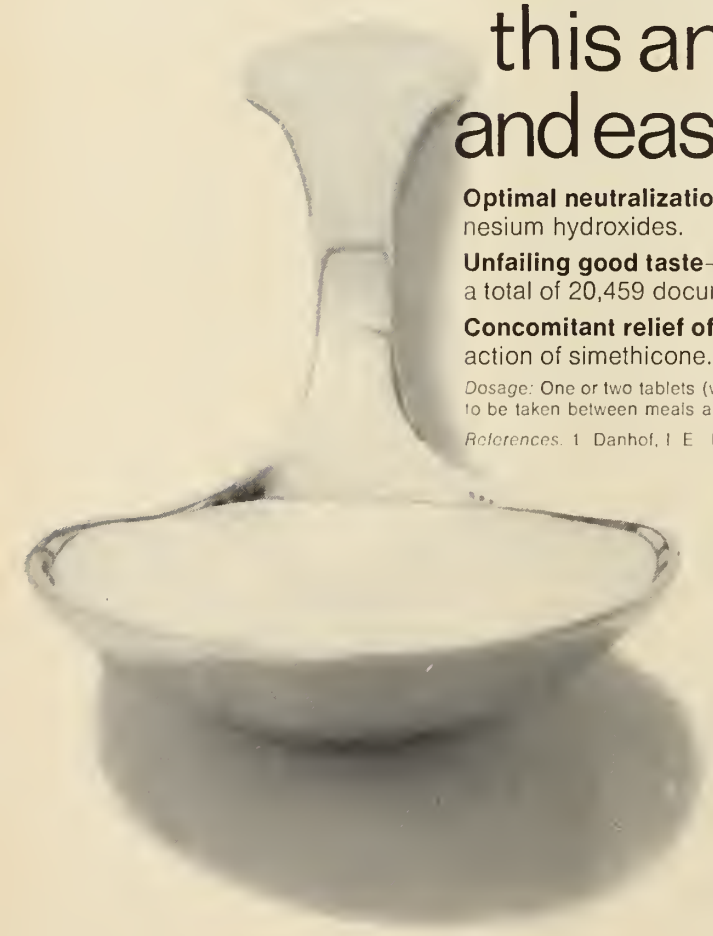
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Peptic ulcer patients find the thousandth dose of this antacid as effective and easy-to-take as the first!



Optimal neutralization—provided by the combination of aluminum and magnesium hydroxides.

Unfailing good taste—confirmed by 87.5% of 104 patients in one study, after a total of 20,459 documented days on Mylanta Liquid or tablets.[1]

Concomitant relief of G. I. gas distress—provided by the proven antiflatulent action of simethicone.[2]

Dosage: One or two tablets (well chewed or allowed to dissolve in the mouth); one or two teaspoonfuls to be taken between meals and at bedtime, or as directed by physician.

References. 1. Danhof, I. E.: Report on file. 2. Hoon, J. R.: Arch. Surg. 93:467 (Sept.) 1966.

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aluminum and magnesium hydroxides *plus* simethicone

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When it's more than a bad cold



your patient can feel better while he's getting better

Achrocidin®

Tetracycline HCl—Antihistamine—Analgesic Compound

Each tablet contains: ACHROMYCIN® Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Caffeine 30 mg.; Salicylamide 150 mg.; Chlorothen citrate 25 mg.

In tetracycline-sensitive bacterial infection complicating respiratory allergy, ACHROCIDIN brings the treatment together in a single prescription—prompt relief of headache and congestion together with effective control of the organisms frequently responsible for complications leading to prolonged disability in the susceptible patient.

For children and elderly patients you may prefer caffeine-free ACHROCIDIN Syrup. Each 5 cc contains: ACHROMYCIN (Tetracycline) equivalent to Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Salicylamide 150 mg.; Ascorbic Acid (C) 25 mg.; Pyrilamine Maleate 15 mg.

Contraindications: Hypersensitivity to any component.

Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.

Precautions: Drowsiness, anorexia, slight gastric distress can occur. In excessive drowsiness, consider longer dosage intervals. Persons on full dosage should not operate vehicles. Nonsusceptible organisms may overgrow; treat superinfection appropriately. Treat beta-hemolytic streptococcal infections at least 10 days to help prevent rheumatic fever or acute glomerulonephritis. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity* reactions—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

Upon adverse reaction, stop medication and treat appropriately.

Lederle

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The go-ahead-and-enjoy-your-vacation summer cold and allergy pill.

Novahistine LP lets you provide effective relief of summer cold and allergy symptoms, lets your patients go ahead and enjoy their vacations.
These continuous-release, decongestant tablets contain a vasoconstrictor-antihistamine formulation that goes to work promptly and lasts for hours. Even the nasal congestion resulting from repeated allergic episodes can usually be relieved by Novahistine LP.

And, convenient twice-a-day dosage lets most patients enjoy relief all day and all night. Use with caution in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

PITMAN-MOORE Division of
The Dow Chemical Company,
Indianapolis, Indiana.

Novahistine® LP decongestant

(Each tablet contains 25 mg. of phenylephrine hydrochloride and 4 mg. of chlorpheniramine maleate.)

DOW

(Continued from Page 1088)

death thousands on thousands of American boys in distant Asia.

Today it continues to "do its thing."

Moral indignation is not born of moral cowardice. But sometimes a wave of moral indignation can engulf the moral coward, and so change his drifting course. That is why the youth decency rallies are so encouraging. It is why public reaction to the Pueblo incident may have healthily changed the course of American history.

And if you want to narrow it further, it is why AMPAC and ALAPAC and the 49 other PAC organizations in the medical field are reviving political consciousness of the importance of expert medical opinion in *all* medical legislation.

The medical profession comes late to the arena of political action; but, hopefully, not too late.

As President-Elect Nixon Saw The Problems of Medicine

In view of subsequent developments, it is interesting to go back to last December's issue of *Michigan Medicine* and reread an article captioned "Nixon's Views on Medical Issues." In abstract form it reads:

"The role of the federal government in medicine should be supportive, never dominating. It should serve as a catalyst and supplement private efforts only as needed. . .

"What is needed is a careful reassessment of medicaid, especially at the local level, with full professional guidance, and emphasis on advice from physicians. . .

"I want to see that every individual who needs medical care is able to get it. But I want it to be good medical care. That's why I want to keep the doctors free from government control as much as possible and oppose extension of a national compulsory health insurance program for everyone. . .

"I oppose compulsory areawide health planning. . .

"I oppose federal control of physicians' fees. Our system is an open, competitive market, assuring an individual the prerogative of setting a value on the services he performs. I would be as opposed to infringing on this right by regulation of physicians' fees as I would be to regulating fees charged by the members of any other profession. . .

"The 100 per cent income tax deduction for non-reimbursable drug and medical expenses of those over 65 should be restored. . ."

And finally of the Hill-Burton Act, he said:

"As demand for hospital facilities increases, additional funds under the Hill-Burton Act for construction and modernization of such facilities will be required to supplement state and local efforts.

"To assure the most efficient use and distribution of Hill-Burton funds, a proposal for bloc grants in this area should be considered."

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TETRACYCLINE HCl
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The Month in Washington

From the Washington Office
American Medical Association

Washington, D. C.—Health, Education and Welfare plans to impose Blue Shield schedules for physicians under Medicaid and to limit payments to hospitals under Medicaid and Medicare drew strong responses from the American Medical Association and the American Hospital Association.

Dr. Dwight L. Wilbur, president of the AMA, urged in a letter to Robert H. Finch, HEW Secretary, that all segments of the health care field be consulted in effecting economies in government-paid health services.

"The American Medical Association is eager to make available to your office the composite experience and judgment of the nation's physicians, who are the principal providers of health care to all the people," Dr. Wilbur said. "The needs and problems of patients in all walks of life, at all income levels, come to their attention, in composite, more than a billion times a year.

"It has always been a principle of both the humanity and the professional code of the physician that no one shall ever be denied quality health care because of his inability to pay. The present concern is how this universal care can best be provided within a viable economic system and in the face of burgeoning demand for medical manpower, services, and facilities. . . .

"The knowledge and judgment of the nation's physicians—as well as of the prepayment plans, health insurance industry, hospitals, the allied health professions, the actuaries and others—must be enlisted in your battle against the health-care portion of the inflation problem."

Dr. Wilbur wrote Finch following the HEW announcement that federal spending on the Medicaid-Medicare programs would be trimmed by $328 million through imposing Medicaid fee schedules based on prevailing Blue Shield rates, limiting mental illness benefits under Medicaid and cutting down hospital overhead allowances in Medicaid and Medicare.

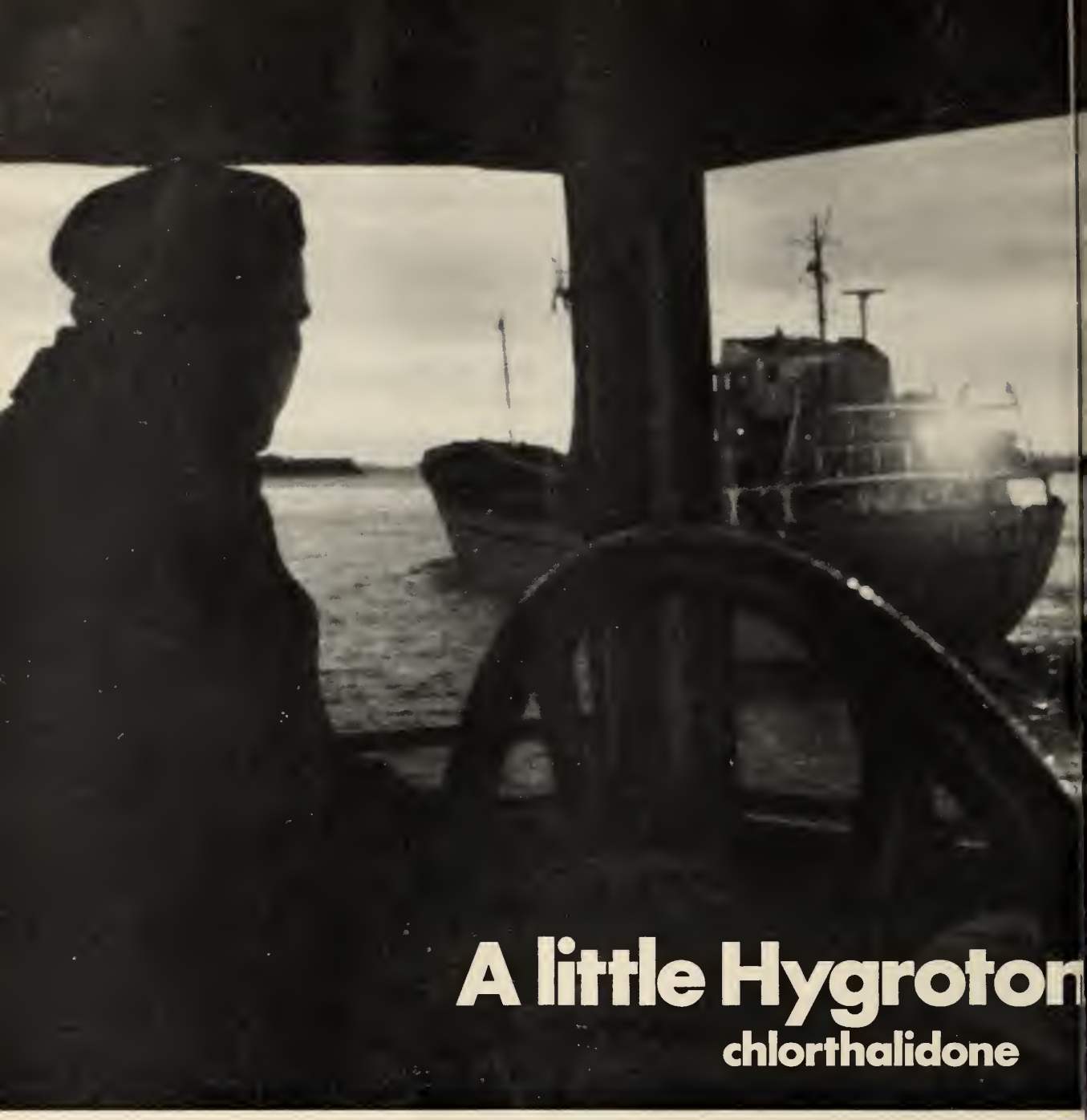
"It is important to recognize that there are many variables in the circumstances of payment for medical and hospital services," Dr. Wilbur said. "Local needs and resources, the educational and motivational levels of the people, the economic conditions of the state and the community are among the reasons for the differences exhibited by the payment patterns of the Blue Shield plans and health-insurance companies.

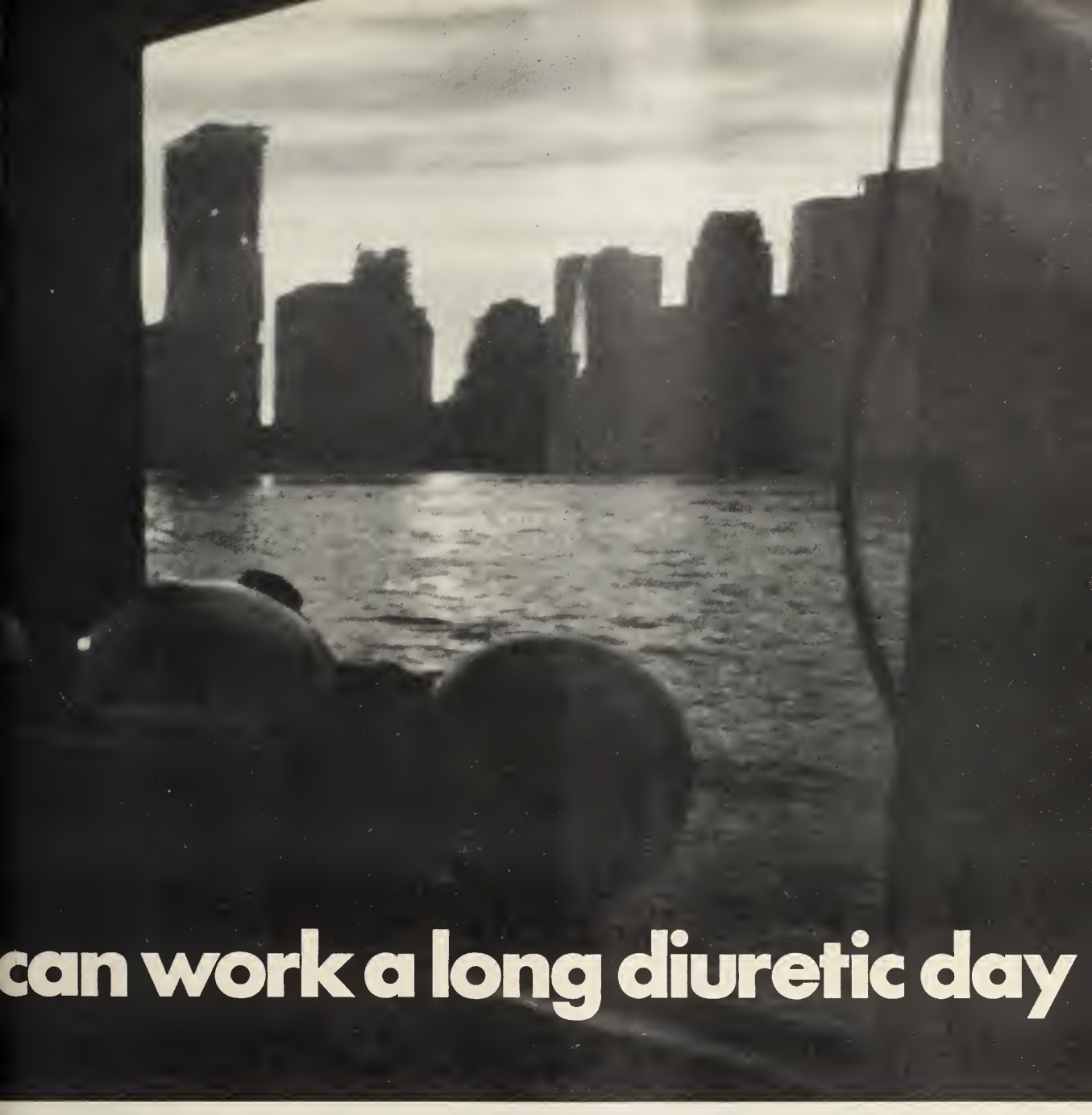
"These circumstances must be the foundation for any policies involving cost and payments. No universal pattern—no matter how many variations it may try to provide—can be imposed on the thousands of localities without wreaking havoc and probably increasing inefficiency and costs."

Concerning the imposition of Blue Shield rates as fee schedules under Medicaid, Dr. Wilbur warned in an address before the American Society of International Medicine in Chicago that a later step "might be that of physicians in groups on salary and abandonment of the fee-for-service principle." He said that physicians, in combatting such government efforts, must accept the major responsibility of keeping fees as moderate as possible.

The American Hospital Association protested in a letter to President Nixon against removal of the two per cent overhead allow-

(Continued on Page 1099)


A little Hygroton
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all the way from one daily tablet to the next
to help control edema and hypertension

Its prolonged action usually provides smooth, sustained diuretic effectiveness; real one-a-day dosage, right from the start; convenience and economy.

Hygroton, chlorthalidone, can cause side effects. And it's contra-indicated in hypersensitivity to the drug and severe renal and hepatic diseases.

Check the prescribing information. It's summarized on the next page.

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A little Hygroton® can work a long diuretic day

chlorthalidone

Indications: Hypertension and many types of edema involving retention of salt and water.

Contraindications: Hypersensitivity and most cases of severe renal or hepatic diseases.

Warning: With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small-bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has been required frequently and deaths have occurred. Discontinue enteric-coated potassium supplements immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur.

Use with caution in pregnant women and nursing mothers since the drug may cross the placental barrier and appear in cord blood and since thiazides may appear in breast milk. The drug may result in fetal or neonatal jaundice, thrombacytopenia, and possibly other adverse reactions which have occurred in the adult. When used in women of childbearing age, balance benefits of drug against possible hazards to fetus.

Precautions: Antihypertensive therapy with this drug should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents, other potent antihypertensive drugs or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. Because of the possibility of progression of renal damage, periodic determination of the BUN is indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated.

Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, the drug should be discontinued and potassium supplements given, provided the patient does not have marked oliguria.

Take special care in cirrhosis or severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended.

Adverse Reactions: Nausea, gastric irritation, vomiting, anorexia, constipation and cramping, dizziness, weakness, restlessness, hyperglycemia, glycosuria, hyperuricemia, headache, muscle cramps, orthostatic hypotension, which may be potentiated when chlorthalidone is combined with barbiturates, narcotics or alcohol, aplastic anemia, leukopenia, thrombocytopenia, agranulocytosis, impotence, dysuria, transient myopia, skin rashes, urticaria, purpura, necrotizing angiitis, acute gout, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Other reactions reported with this class of compounds include: jaundice, xanthopsia, paresthesia, and photosensitization.

Average Dosage: 50 or 100 mg. with breakfast daily or 100 mg. every other day.

Availability: White, single-scored tablets of 100 mg. and aqua tablets of 50 mg., in bottles of 100 and 1000.

(B)46-230-E

For full details, please see the complete prescribing information.

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(Continued from Page 1095)

ance for hospitals. Officially representing the AHA, Ray R. Eppert, Detroit, Mich., hospital trustee, said in a memorandum accompanying the letter to Nixon:

"The recent announcement of a reduction in Medicare reimbursement poses a serious threat to institutional integrity and, therefore, to the ability of hospitals to serve the sick and injured of this nation. Hospitals have been repeatedly assured at the highest levels of government that Medicare changes would not be made without consultation with their designated representative, the American Hospital Association.

"The AHA has tried repeatedly but unsuccessfully to meet with Secretary Finch. It is incredible that the federal government would propose, without any consultation, removal of the two per cent allowance which is a proper component of reasonable costs guaranteed under the law as passed by the Congress.

"The department apparently deemed it unnecessary to consult with the hospital field, and, as far as can be determined, made no serious study of the effect of the proposed reduction on hospitals. Payment of nothing but raw costs will lead. . . .to the serious under-financing of our hospitals."

* * *

Drug combinations became the target of the Senate Small Business Subcommittee's investigation of the prescription drug industry.

Medical school professors critical of drug combinations were called as witnesses in two days of hearings opening this phase of the drug industry probe which began nearly two years ago. It was not indicated when, or even whether, drug company representatives would have an opportunity to defend their combination products before the subcommittee.

Dr. Heinz F. Eichenwald, a National Academy of Science drug specialist, told the subcommittee that "misleading advertising" had lured "the gullible physician" into prescribing useless and sometimes dangerous drug combinations. He also said continued use of drug combinations "amounts to a strong indictment of the ability of many physicians to judge what is effective and what isn't."

Dr. Eichenwald, pediatrics chairman at the University of Texas Southwestern medical school in Dallas, and Dr. William M. M. Kirby, a medical professor at the University of Washington medical school in Seattle, testified on the opening day of hearings on combination drugs conducted by the subcommittee which is headed by Sen. Gaylord Nelson (D., Wis.).

The two physicians were among 30 drug experts who evaluated combination drugs for the National Academy of Science. The experts' unanimous report said the combinations were useless and sometimes dangerous.

The report caused the U. S. Food and Drug Administration to serve notice April 2 that the 78 combination drugs studied by the scientists would be banned from the market unless drug makers could prove the Academy studies were wrong. Drug companies are fighting the FDA order as to many of the combinations that would be banned.

Eichenwald and Kirby both testified doctors are widely prescribing the combinations despite numerous warnings of their potential danger.

Eichenwald said drug firms point to the admittedly widespread use of combinations to state that physicians must therefore have demanded them.

"The opposite is true," Eichenwald's prepared testimony said. "The demand was created by misleading advertising."

In another action, Nelson, D-Wis., urged the FDA to restrict cyclamate-sweetened products to a prescription-only basis.

In a letter to FDA, Nelson said "tens of millions of children and adults across the nation are unwittingly being exposed to poten-

(Continued on Page 1103)

WHAT'S SO WEAK ABOUT THE WEAKER SEX?

OFTEN... HER LOWER G.I. TRACT



Psycho-abdominal Distress: Frequently Female

Women aged 15 to 45 appear to be more prone than men to bloating, cramping pain of stress-related intestinal disturbances such as irritable or spastic colon.[1,2]

Frequently Recurrent

In the experience of many physicians, women are more likely to reappear time after time with repeated complaints of lower G.I. distress.

Requiring Definitive Therapy

Often needed is therapy adequate to control both the somatic and the emotional components of psycho-abdominal complaints.

Definitive Dual Therapy

'Milpath' contains a proven synthetic anticholinergic useful for relieving hypermotility, spasm, and hypersecretion of the gastrointestinal tract.

In addition, 'Milpath' provides a time-tested tranquilizer for mild but effective anti-anxiety action.

With Flexible Dosage

- 'Milpath'-400 (meprobamate 400 mg. + tridihexethyl chloride 25 mg.) Usual adult dose: 1 tablet *t.i.d.* and 2 at bedtime.
- **When less tranquilization is required: 'Milpath'-200 (meprobamate 200 mg. + tridihexethyl chloride 25 mg.)**

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(meprobamate + tridihexethyl chloride)

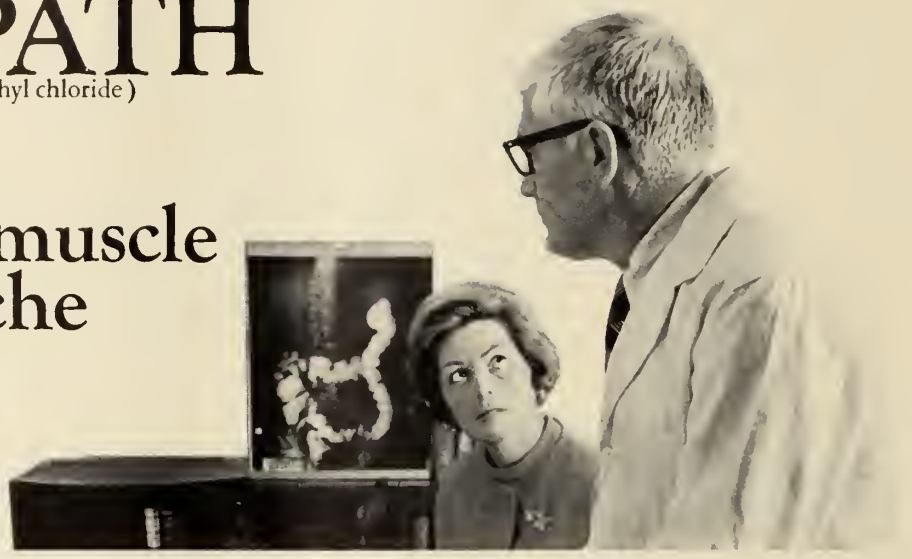
relaxes smooth muscle and psyche

Please see the following page for brief summary of prescribing information.

Gently but firmly MILPATH®

(meprobamate + tridihexethyl chloride)

Relaxes smooth muscle and psyche



Usual Adult Dosage

One 'Milpath'-400 tablet, three times a day at mealtimes, and two at bedtime. For greater anticholinergic effect, two 'Milpath'-200 tablets, three times a day at mealtimes and two at bedtime. Doses of meprobamate above 2400 mg. daily not recommended.

Indications

Useful in organic and functional disorders with hypersecretion and hypermotility of G.I. tract, especially when accompanied by anxiety, neurosis, or tension states. Should be used as an adjunct to all other therapeutic measures.

Contraindications

Tridihexethyl chloride: Urinary bladder-neck obstructions, e.g., prostatic obstruction due to hypertrophy; pyloric obstructions because of reduced motility and tonus: organic cardiospasm (megaesophagus); glaucoma; possibly in stenosing gastric or duodenal ulcers with significant gastric retention.

Meprobamate: Previous allergic or idiosyncratic reactions to meprobamate.

Precautions

Tridihexethyl chloride: Use cautiously in elderly males (possible prostatic hypertrophy).

Meprobamate: Carefully supervise dose and amounts prescribed. Consider possible dependence or habituation (reported occasionally after excessive use), particularly in severe psychoneurotics, alcoholics, ex-addicts. Withdraw gradually (one or two weeks) after excessive dosage for weeks or months to avoid recurrence of pre-existing symptoms (e.g., anxiety, anorexia, insomnia) or withdrawal reactions (e.g., vomiting, ataxia, tremors, muscle twitching; rarely, epileptiform seizures, more likely in those with CNS damage or latent convulsive disorders). If drowsiness or visual disturbance occurs, reduce dose and advise against activity requiring alertness (driving, machinery operation). Effects of excess alcohol may be increased. Grand mal seizures possible in persons with both petit and grand mal. Prescribe cautiously in small amounts to patients with suicidal tendencies. Prescribe with caution to patients with known sensitivity to compounds of similar chemical structure, e.g., carisoprodol.

Side Effects

The following side effects of components may occur with 'Milpath'.

Tridihexethyl chloride: Severe effects rare on recommended dosage. Anticholinergic effects: dry mouth (fairly frequent at oral doses of 100 mg.), constipation or "bloated" feeling. Possible: tachycardia, dilation of pupils, increased ocular tension, weakness, nausea, vomiting, headache, drowsiness, urinary hesitancy or retention, dizziness.

Meprobamate: Drowsiness, sometimes with ataxia, usually controlled by decreasing dosage, occasionally with aid of central stimulants (e.g., amphetamine). Rarely, allergic or idiosyncratic reactions (usually after one to four doses); in mild form: itchy, urticarial or erythematous, maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever, transient leukopenia, and one fatal bullous dermatitis (after meprobamate and prednisolone) reported. More severe, very rare hypersensitivity: fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (one fatal), anuria, anaphylaxis, stomatitis and proctitis. Treat symptomatically (e.g., epinephrine, antihistamines, possibly hydrocortisone); stop and do not restart the drug. Isolated agranulocytosis, thrombocytopenic purpura, one fatal aplastic anemia reported, but only in presence of known toxic drugs, porphyric symptoms reported but relationship not established. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation reported by one observer. Fixed drug eruption with meprobamate and cross reaction to carisoprodol reported.

Suicidal attempts may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse, and death. Excessive dosage has led rapidly to sleep, then reduction of vital signs to basal levels. Empty stomach, and if respiration becomes very shallow and slow, cautiously give CNS stimulants (e.g., caffeine, pentylenetetrazol, amphetamine); also pressor amines if indicated.

Supplied

In two strengths:

'Milpath'-400: Yellow, scored tablets.

'Milpath'-200: Yellow, coated tablets.

Before prescribing, consult package circular.

References

1. Harrison, T. R., et al.: Principles of Internal Medicine, Fifth Edition, New York, The Blakiston Division, McGraw-Hill Book Company, 1966, p. 1019. 2. Bockus, H. L.: Gastroenterology, Second Edition, Philadelphia & London, W. B. Saunders Company, 1964, Vol. II, p. 729 et seq.

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(Continued from Page 1099)

tially serious health hazards by the unnecessary consumption of cyclamate-sweetened soft drinks, cereals, desserts and 'sugar' coated pills."

He added "increasing scientific evidence indicates that cyclamates can cause chromosome breakdown, the birth of undersized offspring in animals, interference with effectiveness of certain antibiotics, persistent diarrhea, liver diseases, skin irritation and eruption, difficulty with blood clotting and high blood pressure."

Cyclamate was originally developed as a sugar substitute for diabetics and others forced to restrict their intake of sweets. The FDA recently proposed regulations on labelling and ingredient content for cyclamate, often used now as a general substitute for sugar.

* * *

The Joint Commission on Mental Health of Children is recommending a broad program aimed at bettering the health of the nation's children and youths at an estimated cost of $6 billion to $10 billion a year.

The Commission recently disclosed its recommendations to the annual meeting of the American Psychiatric Association in advance of its report to Congress. The 54-member commission—which has completed a three-year, $1.5 million study—was established by Congress in 1965.

Sen. Abraham A. Ribicoff (D., Conn.), who introduced the legislation to set up the committee, said he would promptly introduce legislation to carry out the commission's recommendations.

The recommendations included national health insurance for persons up to 21 or 25 years old; family planning and birth control; prenatal care; pediatric care for children up to age of three, and physical and mental health services for older children.

Other recommendations:

—Federal funding for about 100 child development councils to help guide families through the confusion of Government agencies in order to insure diagnostic, treatment and preventive services for children.

—Appointment of a Presidential council of advisers on children and youth, similar in position and prestige to the Council of Economic Advisers.

—Establishment of state commissions and local authorities on child care.

—Federal financing of about 10 evaluation centers to consider the working of the child development councils.

—Publicly supported day care available for all children.

—Federal funds for training child health and welfare personnel.

—Tax incentives to induce people to service in slum areas.

Dr. Reginald S. Louri, Washington, D. C., psychiatrist, is chairman of the joint commission.

Nixon, in a Feb. 19 message to Congress, said:

"So crucial is the matter of early growth that we must make a national commitment to providing all American children an opportunity for healthful and stimulating development covering the first five years of life."

* * *

The chairman of the AMA Committee on Alcoholism and Drug Dependence estimated that five per cent of U. S. college students have tried LSD and 20 per cent of high school and college-age youths have experimented with marihuana and other hallucinogenic drugs.

The chairman, Dr. Henry Brill of West Brentwood, Long Island, N. Y., made the estimate in testimony before the Senate Health Subcommittee.

"And," he added, "although no accurate count has been made, there are signs that the abuse of heroin and other so-called 'hard' narcotics is spreading into the suburbs."

No. 1 Is COPE. . . But Next Is AMPAC and Its 50 Associate PACs

What do you call it? Civic obligation? Enlightened self-interest? Concern for good government?

"I don't care what you call it," Dr. James H. Sammons of Highlands, Texas, chairman of the board of the American Medical Political Action Committee (AMPAC), told an audience of 275 ALAPAC luncheon listeners at the annual Medical Association meeting in Huntsville.



Dr. Sammons

"I call it political involvement."

The desperate need for such involvement, if medical practice as we know it is to survive, was the theme of Dr. Sammons' call for political action. The need, he said, is "not just one day every biennium, but *every* day."

Of the national scene, he said:

"As of this moment, we have a newly elected President who won office by a hairline margin; a House and Senate controlled by his opposition; an Administration just about ready to roll; a new batch of appointed officials exploring the dimensions of their new jobs in the sprawling administrative agencies; and enough problems, foreign and domestic, to keep a thousand Solomons burning the midnight oil.

"They can increase our taxes, commit us to wars, pull our men out of Vietnam, waste our money, spend it frugally, nationalize the nation's health, infringe on our freedoms or do darned nearly anything they feel like doing.

"We hope they will act wisely. But if they don't, the fault is our own for not electing prudent, wise and responsible people."

The irresponsibles, he said, are out numbered in the 91st Congress. But will they be in the 92nd?

"We are in politics because we have to be," Dr. Sammons said. . . And "without the backing of public opinion, the medical profession must sooner or later lose its fight to remain free."

This was in the 1950s, and there were battle scars on the face of medicine. By 1960, when the Forand Bill had been replaced by the King-Anderson Bill, medicine's friends in Congress spoke plainly to medicine's leadership:

They could not resist indefinitely without help. The opposition was strong, well led, and well heeled. The day would soon come when the Administration would be able to muster the votes to pass this Bill. And "what they needed from us was less talk and more political support when their political necks were at stake every other November. . . Finally, they said, political martyrdom was hardly an appealing alternative when *they* were being asked to *die* for *our* principles.

"A year later AMPAC was born."

It will be no surprise to anyone to know that the greatest source of financial support for congresisonal candidates in the nation is COPE, the AFL-CIO political wing. But, Dr. Sammons added, "the second greatest source" is AMPAC and its 50 affiliated PAC organizations, including our own ALAPAC.

This native Alabamian who now heads AMPAC declared: "I have said before that the AMA lobbyists have more friends in Congress with whom to work than ever before . . . Let me add that the politicians of both parties *now see the medical profession as a force to be reckoned with* in the democratic process."

In conclusion Dr. Sammons declared:

"We don't care what party label you wear

if you believe in good government. Good government is the byproduct of good politics.

"We don't care if you cannot devote as much time to PAC activities as some of your colleagues.

"We don't care if your means are more modest than those of your fellows.

"We don't care if your political knowledge is nil, for we can teach you.

"What we care about is that *you* care about *your* government and the sort of men and women to whom it will be entrusted.

"We are, in this free society, citizens first and physicians second.

"We must, if we are to maintain a free society, fulfill both obligations.

"There is work for all of us to do—rewarding work, fulfilling work, work as you would like it to be.

"Join us, if you haven't already.

"And if you *have* joined up again, let's get going.

"Those 1970 elections are just around the corner."

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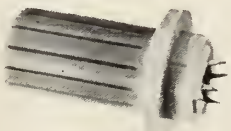
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Stroke and Occlusive Cerebrovascular Disease Review and Surgical Results in 265 Cases

by

J. Garber Galbraith, M. D.

and

Holt A. McDowell, Jr., M. D.

Impairment of blood flow to the brain due to atherosclerotic occlusive vascular disease is now considered to be the major cause of stroke. With the continuing decline in cerebral hemorrhage brought about primarily by effective antihypertensive drugs, the therapy of occlusive cerebral vascular disease assumes increasing importance. Approximately 400,000 individuals sustained a stroke in the United States in 1968,[1] and of these 80 per cent were on the basis of occlusive vascular disease. The problem is further magnified by the fact that two-thirds of the patients admitted to the Joint Study of Extracranial Cerebrovascular Disease were below age 65 and the decade 55-65 contains almost 40 per cent of the stroke population.[2]

Since Fisher[3] in 1951 reemphasized the fact that cerebral infarction is often secondary to extracranial arterial occlusive disease, it has been established that the earliest lesions of atherosclerosis involve the extracranial (surgically accessible) segments of the cerebrovascular arterial system and only later affect the intracranial branches. The earliest disturbance of the cerebral circulation is likely to be a transient regional impairment of blood flow, modified in any given case by the adequacy of collateral flow. These transient ischemic attacks may be on the basis of segmental vessel narrowing aggravated by postural hypotension, head turning, and other factors or, (and probably the most common cause) micro-embolic episodes from ulcerated atherosclerotic plaques. When the occlusive process finally becomes complete occlusion of one or more of the cerebral vessels infarction often results. As this is an irreversible tissue injury, effective stroke therapy must be directed primarily at prevention of infarction, making early diagnosis essential. Transient ischemic attacks with or without cervical bruits dictate the need for four vessel cervicocranial arteriography. Although the initial symptoms are often mild and transient, an aggressive approach is fully justified when one considers the ultimate devastating effects that may follow procrastination.

Since methods for the prevention of atherosclerosis are not yet available, man-

Department of Surgery, University of Alabama Medical Center, Birmingham, Alabama.

Supported by United States Public Health Service, Grants HE-04943 and HE-10618.

agement of this disorder falls primarily into the two following categories:

1. Maintenance of the patency of the extracranial segment of cerebrovascular vessels by surgical removal of obstructing plaques.

2. Support of the collateral circulation when irreversible occlusion has occurred or when the stenotic lesion is inaccessible to direct approach.

Symptoms and Physical Examination

It has been established that 75 to 80 per cent of those patients who suffer a major stroke due to cerebral infarction have had one or more prior warning episodes. It is important that such episodes be recognized promptly and proper evaluation undertaken. The early symptoms of carotid insufficiency include transient lateralized weakness and possibly ipsilateral monocular visual blurring. Pain and impairment of consciousness are notably absent. In vertebrovascular insufficiency vertigo, unsteady gait, and bilateral visual blurring usually occur, sometimes accompanied by thickness of speech, monoparesis. The general physical examination frequently yields evidence of coronary and peripheral vascular disease. Hypertension is accompanied by a high incidence of cerebral atherosclerosis. Carotid palpation is rarely of value since the common carotid pulsation is usually felt in the neck below the bifurcation which is the most common site of stenosis. A 20 mm. discrepancy in arm systolic blood pressure determination should be regarded as significant. It should be emphasized that blood pressure determination should always be taken in both arms.

Special Studies

Lumbar puncture—spinal fluid examination is essential in every case to exclude a bleeding lesion or increased intracranial pressure due to neoplasm.

Brain scan—a brain scan is useful in detecting tumors and areas of hemorrhagic infarction or hematoma.

EEG—the electroencephalogram is performed when the symptomatology makes it difficult to differentiate a transient ischemic attack from a seizure disorder.

Blood chemistries—the high incidence of occult diabetes in patients with cerebrovascular disease dictates a two-hour postprandial blood sugar in all patients and five-hour glucose tolerance test when indicated.

PBI—cholesterol, triglyceride uric acid determination also should be done.

EKG—the high degree of association of cerebrovascular and coronary artery disease makes this test an obvious necessity.

Arteriography

The ultimate diagnostic study is arteriography. An adequate arteriographic study to evaluate cerebral occlusive vascular disease must visualize all four vessels supplying the brain from their cervical and thoracic origin to intracranial termination. The aortic arch and innominate artery should be visualized. This can be accomplished by several acceptable methods. The risk of this type of arteriographic study is now acceptable with a grave complication rate in experienced hands ranging from 0.7 per cent to 1.2 per cent.[1] To enable the surgeon to make an intelligent decision the above studies are mandatory and intracranial vessels should be visualized in all cases to rule out unexpected space occupying lesions, A-V malformation, aneurysm, etc.

The arteriographic findings in 3788 cases reported by the Joint Study of Extracranial Vascular Occlusive Disease are summarized in Fig. 1.[2] As can be seen a total of 74.5 per cent had surgically accessible lesions.

Treatment

Management must be based on an anatomical diagnosis, determined by arteriography, coupled with the clinical status of the patient on admission. Where the neurologic status is satisfactory and symptoms only transient or mild, early evaluation is im-

FIGURE 1

JOINT STUDY—3,788 CASES

4—VESSEL ARTERIOGRAPHY

No Lesion	19.4%
Inaccessible Lesion Only	6.1%
Accessible Lesion Only	41.2%
Accessible + Inaccessible	33.3%

portant in order to institute proper corrective measures to prevent cerebral infarction.

When the neurologic status is impaired to either a moderate or marked degree, early intensive supportive therapy is advisable and only after the patient has become neurologically stable are further investigative measures such as arteriography justified. In the acute phase plasma volume expanders and vasopressors are helpful and steroids have been advocated by some to prevent brain swelling. Nasogastric suction is sometimes necessary when vomiting and the attendant hazard of aspiration is present, and early attention to adequate pulmonary ventilation is extremely important. Acetazolamide (Diamox) and papavine have been used by some in the acute phase and are possibly of benefit. In selected cases long-term anticoagulation may be beneficial.

When cerebral infarction has occurred, intensive nursing care is of paramount importance. Early physical therapy and a planned program of rehabilitation will aid in minimizing the residual deficit thus restoring many stroke victims to some measure of self-sufficiency.

Surgically accessible stenotic lesions should be corrected. The risk of these procedures is now nominal and long-term results in terms of patency of the involved vessel are very gratifying.

Technique

The technique employed by us for the correction of cervical carotid bifurcational stenosis is the standard endarterectomy. We have found it necessary in 90 per cent of the cases to extend the arteriotomy superiorly into the internal carotid artery. In many instances the stenotic plaque extends superiorly as a projection usually on the posterior wall of the vessel which is not appreciated arteriographically. We feel that direct visual extirpation of the plaque superiorly is important in preventing the occurrence of postoperative thrombosis due to an intimal flap. When the arteriotomy extends into the internal carotid it is necessary to reconstruct the vessel with a patch, and an autogenous saphenous vein patch is our preference.

Vertebral ostial stenosis is attacked surgically much less frequently than carotid disease and our experience is therefore not as extensive. However we have employed vein patch angioplasty in most instances. Rarely an occasional patient will require only lysis of periarterial fibrous bands. One patient had successful correction of vertebral ostial stenosis by suturing the proximal vertebral end-to-side to the common carotid after detaching it from the subclavian.

Correction of the vertebral steal syndrome is done by common carotico-subclavian Dacron shunt performed through a cervical supraclavian incision. We have not found it necessary to resect the clavicle in any cases. Although aortico-subclavian shunt is advocated by some we believe that the attendant increase in mortality in this age group when thoracotomy is done does not justify this approach in view of the low mortality and technical success that may be achieved via the cervical route.

More important than the above details of surgical technique however is the employment of methods to prevent cerebral ischemia during the necessary period of vascular occlusion. The most important factors in our opinion are: general anesthesia (usually flouthane), intraoperative monitoring, maintenance of blood pressure at or above pre-

operative levels, avoidance of hypocarbia and usually mild hypercarbia is maintained. The protection offered by low molecular weight dextran is controversial and of probable minor importance but we administer it intravenously prior to and for two to three days following surgery.

Prior to the reported series local anesthesia was used for carotid endarterectomy with a 17 per cent incidence of postoperative neurologic deficit. General anesthesia diminishes the O_2 demand of the brain and some anesthetic agents (flouthane) are probably cerebral vasodilators. The importance of using general anesthesia cannot be over emphasized.

During cerebrovascular surgery we monitor continuously the per cent O_2 saturation from the ipsilateral sinus via the jugular vein,[5] the pO_2, pCO_2 and pH of the arterial blood via a catheter in the proximal common carotid and pCO_2 of the expired air via an electrode introduced in the endotracheal tube.

The patient's blood pressure is kept at or 10-20 mm. mercury higher than the preoperative level using neosynephrine as a vasopressor if the central venous pressure is normal which is monitored through a central venous line and if the EKG monitor indicates no myocardial ischemia to account for hypotension.

By introducing CO_2 into the anesthetic mixture in amounts governed by the respiratory and arterial pCO_2 values we keep the pCO_2 no lower than 35 mm. and usually 40-50 mm. This has proven to be more satisfactory in our hands than controlled hypoventilation to obtain hypercarbia. Intravenous Diamox given five minutes prior to occlusion seems to be as effective as hypercarbia in producing cerebral vasodilatation presumably by increase in tissue pCO_2.[6]

Fig. 2 shows the monitoring aids used during the performance of surgery for extracranial occlusive disease in 334 procedures (265 cases) performed at the Medical College of Alabama over the past seven years. We believe that these techniques are of immeasurable value in insuring the safety of the procedure. Fig. 3 shows the complica-

FIGURE 2

MONITORING AIDS IN CAROTID SURGERY

Blood Pressure

Arterial pO_2, pCO_2, pH

Jugular Venous O_2 Saturation

Respiratory pCO_2

EEG

EKG

Central Venous Pressure

Intraarterial Pressures

FIGURE 3

ANALYSIS OF COMPLICATIONS 1961 TO MAY 1968

265 Cases—334 Procedures

Post Operative Mortality	10 (3%)
Worsening	21 (7%)

FIGURE 4

MORTALITY JANUARY 1961 TO MAY 1968 265 SURGICAL CASES

Cerebrovascular Disease	11
Other	
Myocardial Infarct	15
Cancer	15
Miscellaneous	8
Total Deaths	49

tions in this group. There was only 3 per cent postoperative mortality and neurologic worsening following surgery. Fig. 4 summarizes the causes of death in those patients expiring during this seven year period. It is significant to note that only eleven surgical patients expired from cerebrovascular causes during the entire period 1961-1968 (of a total of 265 cases).

Summary

Extracranial arterial lesions are associated with early reversible symptoms of cerebrovascular insufficiency. Patients with a history of transient neurologic deficit should be thoroughly evaluated including four vessel cervico-cranial arteriography and demonstrated surgically accessible lesions corrected. Surgical procedures now carry only a nominal risk. Monitoring techniques, controlled hypertension, mild hypercarbia and the use of general anesthesia are important factors contributing to the safety of surgical procedures on the extracranial vessels.

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An Emergency Air-Ground Transport System For Newborn Infants With Respiratory Distress Syndrome

L. J. Arp, Ph. D.,* R. E. Dillon,**
Mary Tom Long, M. D.,*** and C. L. Boatwright, M. D.****

Introduction

Respiratory distress in the newborn infant has been the largest single cause of death during the first week of life. About 17 per cent of all premature infants are affected by respiratory distress and about half of these die. About 25,000 infants expire each year in the United States.[1] This number represents between 30 per cent and 40 per cent of all newborn deaths.[2] Nearly half of the infants weighing less than 3½ pounds who now survive their respiratory distress may be mentally defective.[3] Dr. J. F. Lucey, writing in the January, 1968 issue of "Hospital Practices," cites a study carried out at the Boston Lying-In Hospital where it was found that mortality among premature infants accounted for 71 per cent of all liveborn infant deaths. The death rate in low birth weight infants was said to have shown ". . . no improvement in 21 years . . ."

These grim statistics do more than suggest that high risk infants delivered in the average hospital in this country face great hazards. Indecision, uncertainty, and delay in resuscitation and treatment can result in irreversible anoxic tissue damage to the brain and other vital organs. The tragic results, many times ascribed to immaturity rather than anoxia, are known all too well. The wait-and-see, hands-off procedures, using oxygen and buffer therapy alone for treating respiratory distress has been proved inadequate by experience.

Newborn Intensive Care Nurseries are needed throughout the country. However, the specially trained personnel and new equipment designed specifically for the newborn infant are not generally available.

A dramatic decrease in infant morbidity and mortality rates has been achieved when nursing personnel, trained in the use of a special infant respirator, blood-gas, and physiological monitoring equipment, have been available.[4, 5] The average survival rate which can be expected for all infants weighing no more than 1,000 grams (2 pounds-3 ounces) is about 10 per cent to 15 per cent.[6] These figures include those not afflicted with Respiratory Distress Syndrome (R. D. S.). In contrast, the survival rate for infants weighing no more than 1,000 grams, with all 19 infants with respiratory distress, in a study by Arp, et. al., was 31.7 per cent.[4, 5] Special equipment for treating the distressed infant provided a similar striking improvement in the survival rate for infants weighing no more than 1,500 grams (3 pounds-5 ounces) where the normal survival rate for all infants in this weight group, including those who were not in respiratory distress, is about 29.3 per cent.[6] The survival rate in the study by Arp, et. al., for 42 infants, with all infants in respiratory distress, and weighing no more than 1,500 grams, was 47.6 per cent.[4, 5]

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****Church Street, Blacksburg, Virginia.



Figure 1. The V. P. I. Airplane.

A Plan For The Immediate Future

It is unlikely that every hospital will be able to assemble and train a team of specialists to cope with the vexing problems associated with the distressed newborn in the very near future. In addition, the special infant respirators needed for the successful treatment of newborn Respiratory Distress Syndrome will not be generally available for some time. Blood-gas analyzing and physiological monitoring equipment is expensive and requires very skilled and specially trained nurses and/or technicians. Personnel with this specialized training are not readily available. The most difficult problem to solve, however, is that of convincing the nursing supervisors and the hospital administrators that each distressed newborn must have a Graduate or Licensed Practical Nurse for uninterrupted observation and attention as long as the Physician carries the infant on the "critical" list. Each Graduate or Licensed Practical Nurse can manage 2 infants only after the patient is removed from the "critical" list.

In view of the requirements just outlined, it becomes very clear that all hospitals cannot, in the very near future, support and operate an Intensive Care Nursery as it must be structured in order to reduce today's tragic infant morbidity and mortality rates. Intensive Care Nurseries must be established in population centers to provide the best medical care known today to the largest number of people. Infants from less populated areas will need to be transported to these specially staffed and equipped Intensive Care Nurseries. New transport systems must be devised to reduce the time and risks involved in moving the high risk patients to the centers before the patient becomes critically ill. Physicians will be called upon to make the decision to transfer patients long before they can be absolutely certain that the patients will not survive in the average hospital. The patients must be viable when

they arrive at the Intensive Care Nursery. New equipment and techniques cannot perform the miracle of restoring life to the dead.

A very general plan has been outlined for supplying the best medical care known for the distressed newborn. This plan has been put into operation by the Virginia Polytechnic Institute, Blacksburg, Virginia, in cooperation with the Roanoke Memorial Hospitals, Roanoke, Virginia.

A New Transport System For Infants With R. D. S.

A twin engine Beechcraft airplane has been made available by Virginia Polytechnic Institute's President, Dr. T. Marshall Hahn, Jr., for transporting newborn infants with respiratory distress from hospitals lacking the needed specalized staff and equipment to the Intensive Care Nursery at the Roanoke Memorial Hospitals. The transport service described in the following pages will be available at the request of Physicians and without charge until the new infant respirator becomes available commercially. The V. P. I. airplane can land at any hard surfaced airport having a runway at least 2,800 feet long. The runway must be lighted for a night flight. The service may be obtained any time of the day or night that the airplane and infant respirators are not in use. To obtain this service or information, call Dr. L. J. Arp, Area Code 703-552-6574 or Area Code 703-552-1162, or Mr. R. E. Dillon, Area Code 703-552-2507.

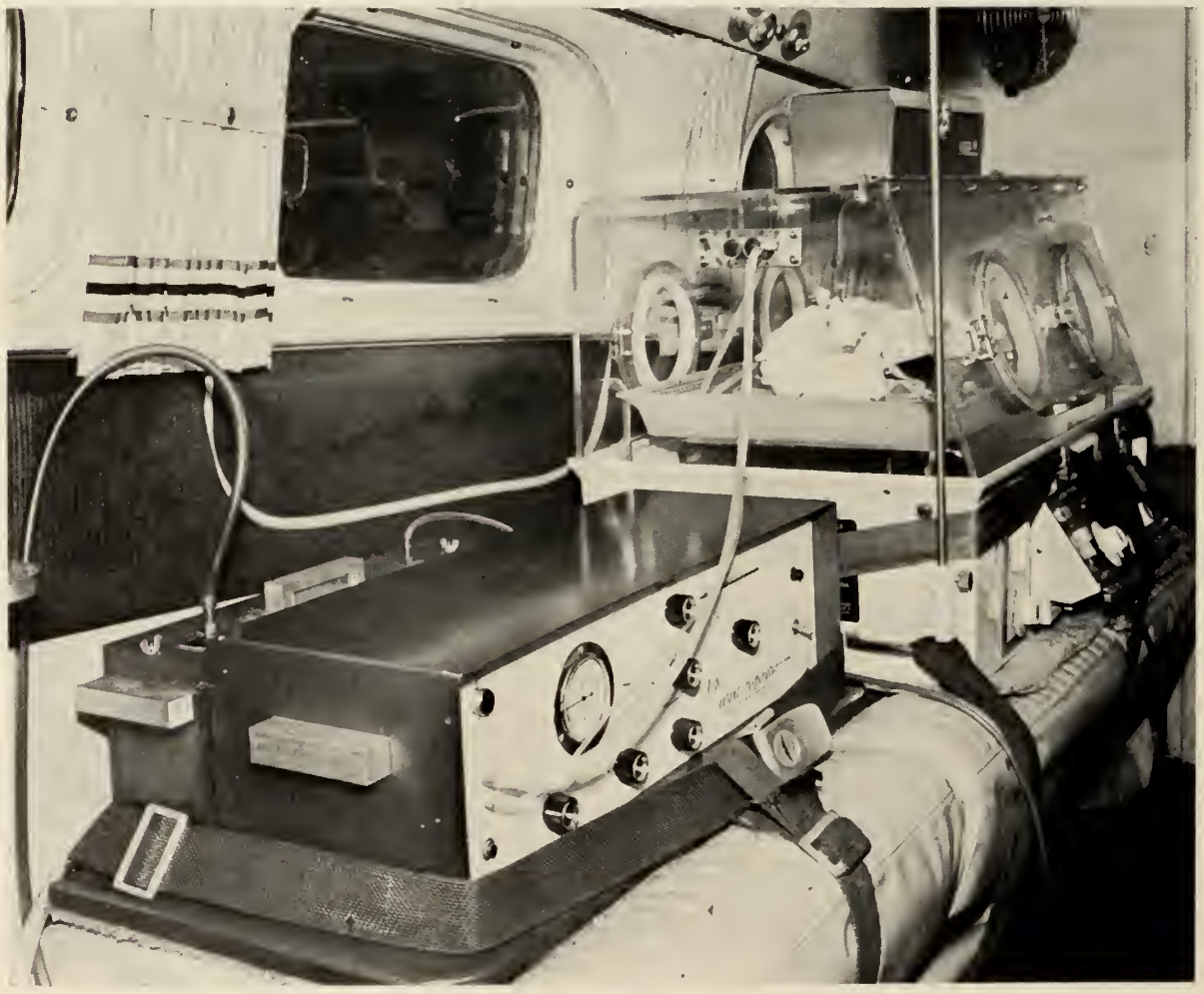


Figure 2. The ARP Infant Respirator and the Armstrong Servo-Control Incubator.

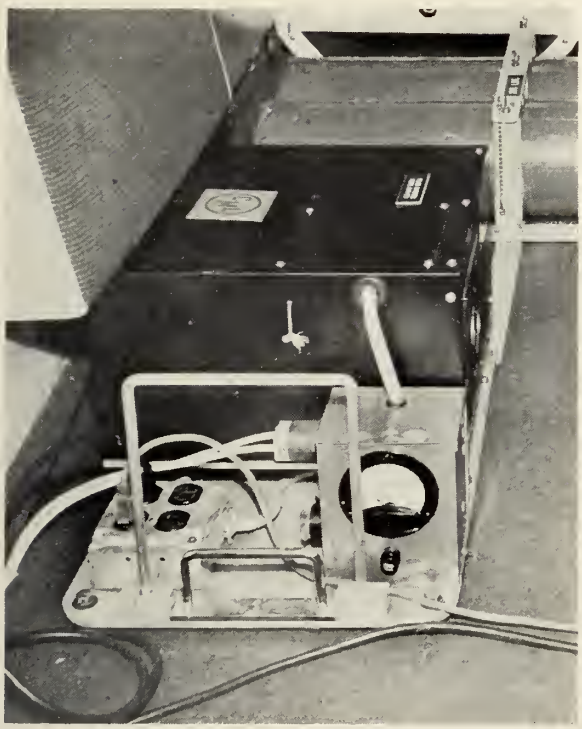


Figure 3. The C. M. L. Static Inverter Power Supply.

Figures 1, 2, and 3 show the airplane equipped with an ARP Infant Respirator, an Armstrong Servo-Control Incubator,[1] a solid state static inverter[2] to convert the airplane's 28 volt power supply to 117 volts, and a redundant oxygen supply. The volunteer flight crew includes the pilot, Mr. E. S. Warner, the co-pilot, Mr. Bill Byrne, L. J. Arp, Ph. D., Mr. R. E. Dillon, and Mary Tom Long, M. D., or C. L. Boatwright, M. D.

When a request is received for emergency air transportation for a distressed infant, the physician in charge of the transfer is requested to "stand-by" at the hospital with the infant in a warm incubator containing an atmosphere of 100 per cent oxygen. As the pilot approaches the pick-up point and a precise landing time becomes known, the control tower is requested to call the waiting physician to give him the landing time. If refueling is required, the completion time for this operation is passed on to the physician so that there is no delay in the transfer of the infant to the airplane system. The infant in respiratory distress is transferred to the special holding and positioning fixture in the Armstrong Incubator. A restraining blanket is placed around the holding fixture as a safety belt for the infant. After respiratory assistance is started with the ARP Infant Respirator, using a nose mask as the patient-machine interface,[4,5] the airplane is ready to take off for the Roanoke airport.

As the pilot nears the Roanoke airport and the arrival time becomes known, the control tower is requested to notify the Intensive Care Nursery at the Roanoke Memorial Hospitals of the arrival time. Figure 4 shows the specially equipped ambulance with redundant oxygen supply, a battery powered inverter to supply 117 volts, alternating current to power the incubator and the self-contained respirator which is dispatched with a nurse from the Intensive Care Nursery to meet the arriving patient. The incubator is transferred from the airplane to the ambulance support system without interrupting respiratory assistance. The ambulance support system is then rolled up a special ramp into the waiting ambulance (as shown in



Figure 4. The Transport Ambulance System.

1. Supplied by: Ohio Medical Products, Inc., 1400 E. Washington Avenue, Madison, Wisconsin.

2. Supplied by: Communications Measurements Laboratory, Inc., 350 Leland Avenue, Plainfield, New Jersey.

figure 5). The entire portable unit is then clamped securely in place to prevent any shifting of the unit during the trip from the airport to the hospital. Respiratory assistance remains uninterrupted as the infant is transferred from the ambulance, up the elevator, and into the Intensive Care Nursery.

Use of the battery powered respiratory support unit from the ambulance is not limited to the transfer of distressed infants from the airport to the hospital. This unit is used to supply respiratory support for infants during transfer from near-by hospitals to the Intensive Care Nursery when it is either impossible or impractical to use the airplane. The portable unit is on stand-by in the delivery suite and in surgery for all deliveries and Caesarean sections. The unit is also used to supply uninterrupted respiratory support while the infant is transported to the X-ray department, during radiological observations, and while using the X-ray intensifier. It has been observed that an interruption in respiratory support for even a minute or two can trigger irreversible changes in the patient which will cause death.

Conclusions

The degree of success in reducing newborn infant morbidity and mortality by supplying respiratory assistance is directly related to the condition of the infant at the time he is provided that assistance. It has been found that the transfer is generally an exercise in utter futility if the referring physician delays

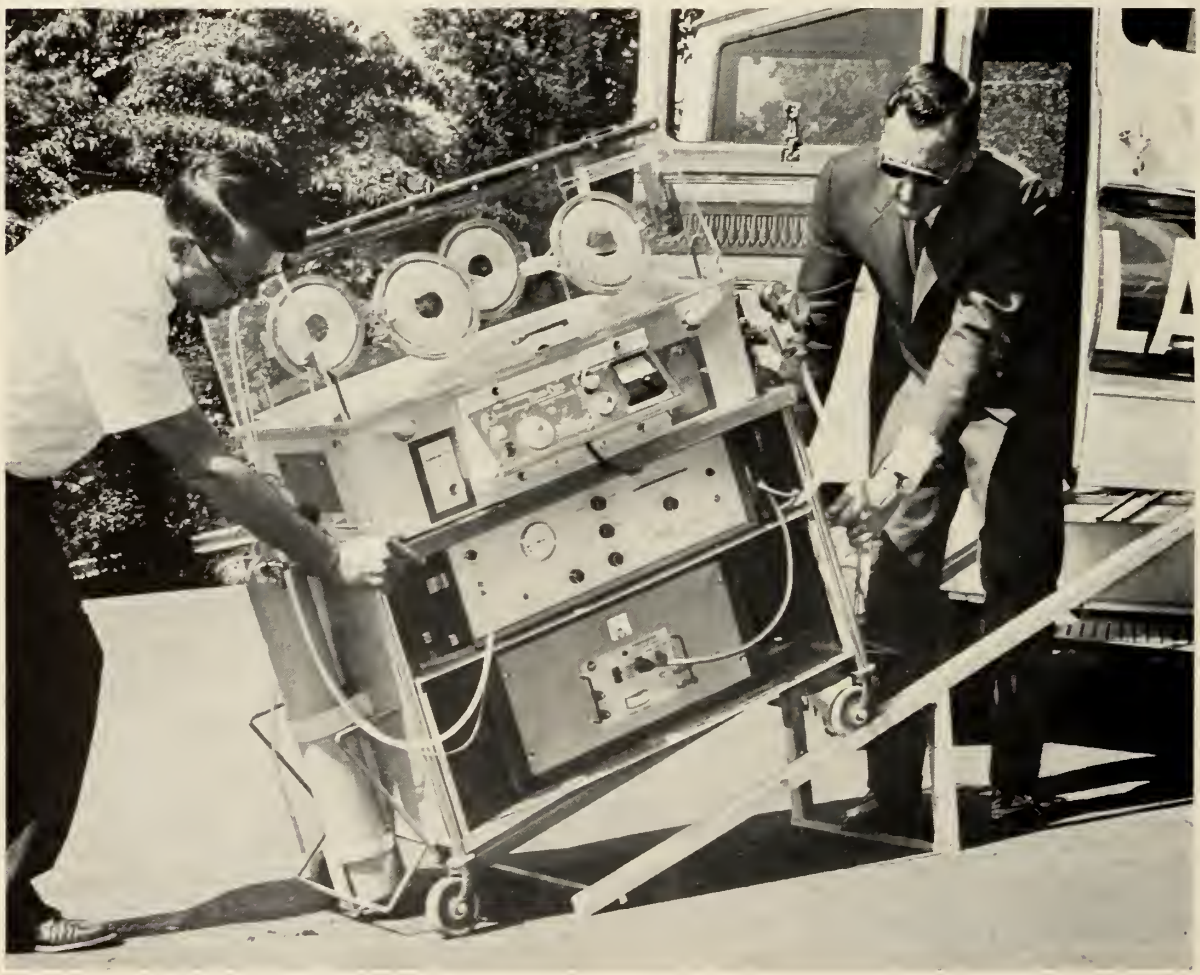


Figure 5. Respiratory Support Continues Uninterrupted Throughout Transfer.

in transferring the distressed infant until he is quite sure that the infant will not survive in the local hospital nursery. The concept of the absolute necessity for an early transfer and start of intensive and comprehensive support for the distressed infant has been most difficult to convey. The last-ditch stand by a physician using oxygen and buffer therapy has been proved by experience to be inadequate in many cases. No surgeon waits for a vermiform appendix to perforate before taking a patient into surgery. Likewise, the infant with R. D. S. has the best chance for survival if respiratory assistance is started immediately after the first clinical signs of trouble are observed.

The integrated air-ground transport and support systems described in this paper have been used successfully. The key to this successful operation is teamwork. This teamwork can only be accomplished through education, training, and dedication to the idea that better treatment is possible and can become a reality through cooperative understanding and advanced planning. Once the hardware and support teams are available, the only obstacles remaining in the path leading toward success are indecision and delays.

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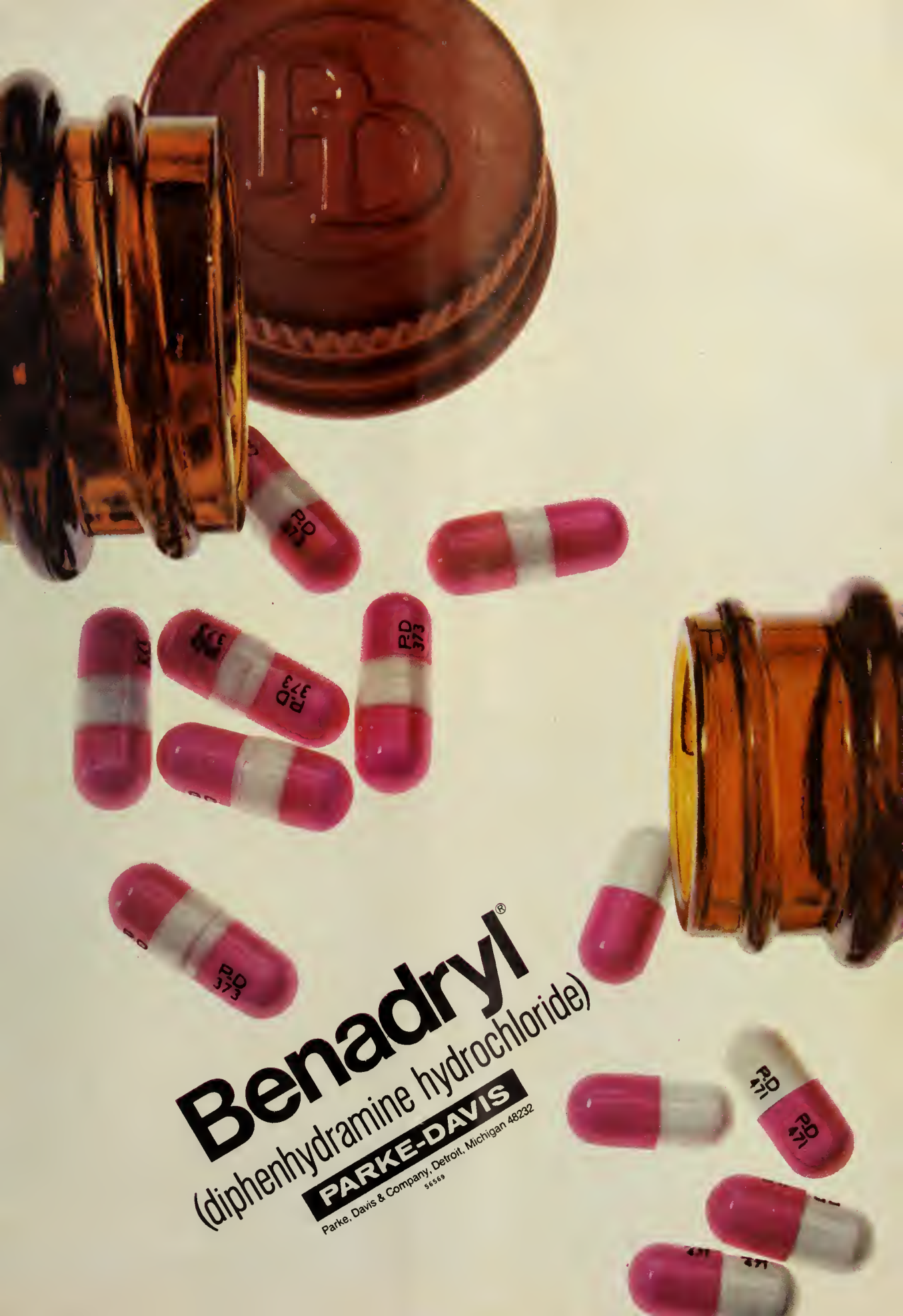
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*Complete list of references on request.

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Reaves, John Earl, b 38, mc Ala. 64, sb 65, Medical Arts Building, Anniston, Ala. 36201.

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(Continued on Page 1125)


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Wood, William Gross, Lafayette, Ala. 36862 —deceased January, 1969.

Choctaw County

Miller, Samuel T., Yantley, Ala. 36924—deceased.

Etowah County

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Hill, Vivian Huston, 1250 Dauphin Street, Mobile, Ala. 36604—deceased.

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McCaslin, Dan L., present Birmingham, Ala. 35203, to 2352 Mockingbird Lane, Birmingham, Ala. 35225.

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Mobile County

Harlin, Robert S., present Mobile, Ala. 36604, to 166 Louiselle St., Mobile, Ala. 36607.

Martin, Henry F., present Mobile, Ala. 36602, to P. O. Box 117, Point Clear, Ala. 36564.

Montgomery County

Martin, Farris J., present Montgomery, Ala. 36104, to 359 South Ripley Street, Montgomery, Ala. 36104.

Morgan County

Bragg, John C., present Decatur, Ala. 35601, to 651 Jackson Street, Decatur, Ala. 35601.

Greer, Hugh D., present Decatur, Ala. 35601, to 1201 Somerville Road, Decatur, Ala. 35601.

Smith, John T., Jr., present Decatur, Ala. 35601, to P. O. Box 2211, Decatur, Ala. 35601.

Tuscaloosa County

Oldshue, Isabel B., present Tuscaloosa, Ala. 35401, to Student Health Service, Boy Y, University, Ala. 35486.

MEMBERS TRANSFERRED

Calhoun County

Canup, Clarence Neal, 3310 Henry Rd., Anniston, Ala. 36201. (Transfer from member of Cleburne County to member of Calhoun County Medical Society.)

Gantt, James Stewart, 214 East 8th Street, Anniston, Ala. 36201, (Transfer from member of Jefferson County to member of Calhoun County Medical Society.)

(Continued on Page 1128)

"Shall I order Maalox?"





"Yes. Patients respond well to it, and seem to take it more faithfully."

Works well · Doesn't constipate · Tastes good · Economical

Supplied: Maalox Suspension (12 fl. oz.). *Also available:* Maalox No. 1 Tablets (0.4 Gm.) : no sugar, low sodium content. Maalox No. 2 Tablets (0.8 Gm.) : double strength for double antacid action.

THE NUMBER ONE ANTACID

Maalox®

MAGNESIUM-ALUMINUM HYDROXIDE

RORER

WILLIAM H. RORER, INC.
Fort Washington, Pa. 19034

(Continued from Page 1126)

Jefferson County

Hare, William Kendrick, Pharmacology Dept. Univ. of Alabama, Birmingham, Ala. 35233. (Transfer from member of Jefferson County to nonmember of Jefferson County Medical Society.)

Madison County

Carter, William Wood, 821 Gallatin Street, Huntsville, Ala. 35801. (Transfer from member of Madison County to nonmember of Madison County Medical Society.)

Smith, Almoth Horton, 401 Lowell Drive, Huntsville, Ala. 35801. (Transfer from member of Madison County to nonmember of Madison County Medical Society.)

Marshall County

Erwin, Claude Campbell, P. O. Box 220, Albertville, Ala. 35950. (Transfer from member of Marshall County to nonmember of Marshall County Medical Society.)

Mobile County

Moss, Charles Smith, 850 St. Anthony Street, Mobile, Ala. 36603. (Transfer from member of Walker County to nonmember of Mobile County Medical Society.)

Russell County

Floyd, Cyril Franklin, Russell County Health Department, Phenix City, Ala. 36867. (Transfer from member of Russell County to nonmember of Russell County Medical Society.)

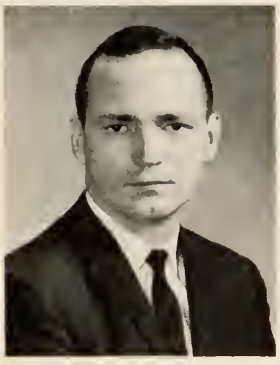
NONMEMBERS TRANSFERRED

Calhoun County

Stallworth, Nicholas Robert, 103 Church St., Jacksonville, Ala. 36265. (Transfer from nonmember of Calhoun County to member of Calhoun County Medical Society.)

DOUBLE RESPONSIBILITY

The Chairman of the Department of Pediatrics, Medical College of Alabama, also becomes medical director of the Children's Hospital, with the appointment of Dr. John W. Benton, Jr., just announced jointly by Dr. Clifton K. Meador, dean of the Medical College, and Alfred M. Shook III, president of the Board of Trustees, Children's Hospital. For the last eight months, Dr. Benton has served as interim department chairman.



Dr. Benton

RETIRED DOCTOR DIES

Dr. Carlton W. Winsor, retired physician, died in a Mobile hospital after a long illness.



Dr. Winsor

A veteran of World Wars I and II, for nine years director of Mobile's Regional Blood Center, a former official of the Mobile chapter, A. G. P., survivors include his widow, two daughters, Miss Nancy Lou Winsor, Mobile, and Mrs. Robert Conover, Chicago; two sons, Robert L. B. Winsor, New York City, and David C. Winsor, Mobile. Funeral and burial were in Mobile.

(Continued on Page 1130)

a broad-spectrum antibiotic for the diabetic:

threat or therapy?



Disordered metabolism makes her prone to bacterial infection —and to moniliasis.

When she needs tetracycline, she may also need protection against the threat of fungal overgrowth. And Tetrex-F can provide both.

Each capsule contains 250 mg. of tetracycline phosphate complex to control sensitive bacterial pathogens... and nystatin, 250,000 units, as a precautionary measure against troublesome vaginitis, proctitis or other monilial infections. However, superinfection with other, nonsusceptible organisms may occur.

Tetrex-F®
(tetracycline phosphate complex-nystatin)

PRESCRIBING INFORMATION: Tet-F. 5—2/23/67. For complete information consult Official Package Circular.
Indications: Infections of respiratory, gastrointestinal and genitourinary tracts and skin and soft tissues due to tetracycline-sensitive organisms, in patients with increased susceptibility to monilial infections.
Contraindications: The drug is contraindicated in patients hypersensitive to its components.
Warnings: Photodynamic reactions have been produced by tetracyclines. Natural and artificial sunlight should be avoided during therapy. Stop treatment if skin discomfort occurs. With renal impairment, systemic accumulation and hepatotoxicity may occur. In this situation, lower doses should be used. Tooth staining and enamel hypoplasia may be induced during tooth development (last trimester of pregnancy, neonatal period and childhood).
Precautions: Bacterial superinfections may occur. Infants may develop increased intracranial pressure with bulging fontanels. In gonorrheal therapy, serologic tests for syphilis should be conducted initially and monthly for 3 months.
Adverse Reactions: Glossitis, stomatitis, nausea, diarrhea, flatulence, proctitis, vaginitis, dermatitis, and allergic reactions may occur.
Usual Adult Dosage: 1 capsule q.i.d. Continue for 10 days in Beta-hemolytic streptococcal infections. Administer one hour before or two hours after meals.
Supplied: Capsules, bottles of 16 and 100. Each capsule contains tetracycline phosphate complex equivalent to 250 mg. tetracycline HCl activity and 250,000 units of nystatin.

For Oral Suspension, 125 mg. tetracycline and 125,000 u. nystatin/5 ml., 60 ml. bottles. **A.H.F.S. Category 8:12**

BRISTOL

BRISTOL LABORATORIES
Division of Bristol-Myers Company
Syracuse, New York 13201

Three McLaughlin Brothers Practice Medicine In South Alabama

Half of the six McLaughlin brothers went their separate ways, one to practice dentistry at Auburn, one to become a veterinarian in Port Allen, La., and one—the only one of the six who isn't known as "Dr. McLaughlin"—is with the United States Engineers in Savannah.

Each of the remaining three is proud to sign the significant initials M. D. after his name, and all are in general practice, one in Mobile, where there are 300 other active members of the Medical Association of the State of Alabama, and two in Ozark, where there are only five other doctors practicing. All three have their medical degrees from the University of Alabama.

Two of these three are members of the Board of Directors of ALAPAC (the Alabama Medical Political Action Committee), one from the First Congressional District, the other from the Third.

Elder of the three brothers, Dr. Leon Durwood McLaughlin, is practicing medicine in Ozark, as is the brother next to him, Dr. Robert Joseph McLaughlin, an ALAPAC director.

Youngest of the three, Dr. Max Victor McLaughlin, in general practice in Mobile, is ALAPAC's director from the First district.

All three, born in Blue Springs, Ala., received their medical degrees from the University of Alabama in Birmingham, where their father before them received his, and where the son of one of them—Leon Durwood, Jr.—was to receive his at this graduation. Appropriately, Dr. Leon Durwood McLaughlin, Jr., is to intern at Mobile Infirmary, just as did his father, his two uncles and his grandfather.

An educated guess might fix the name McLaughlin as Irish. It would be correct if one stays within the time bounds of 15 centuries. But the first of them to arrive on the rocky coast of Eire doubtless sailed there in a Viking ship.



Left to right: Durwood, Max, Bob

There are five ways of spelling it:—*Mc*Laugh*lin*, *Mac*Laughlin, Mc*Lough*lin, *Mac*Lach*lan*, McLaugh*lan*. But however you spell it, it means "son of Lochlainn or Lochlann" (Norway); the son of one who came from Norway.

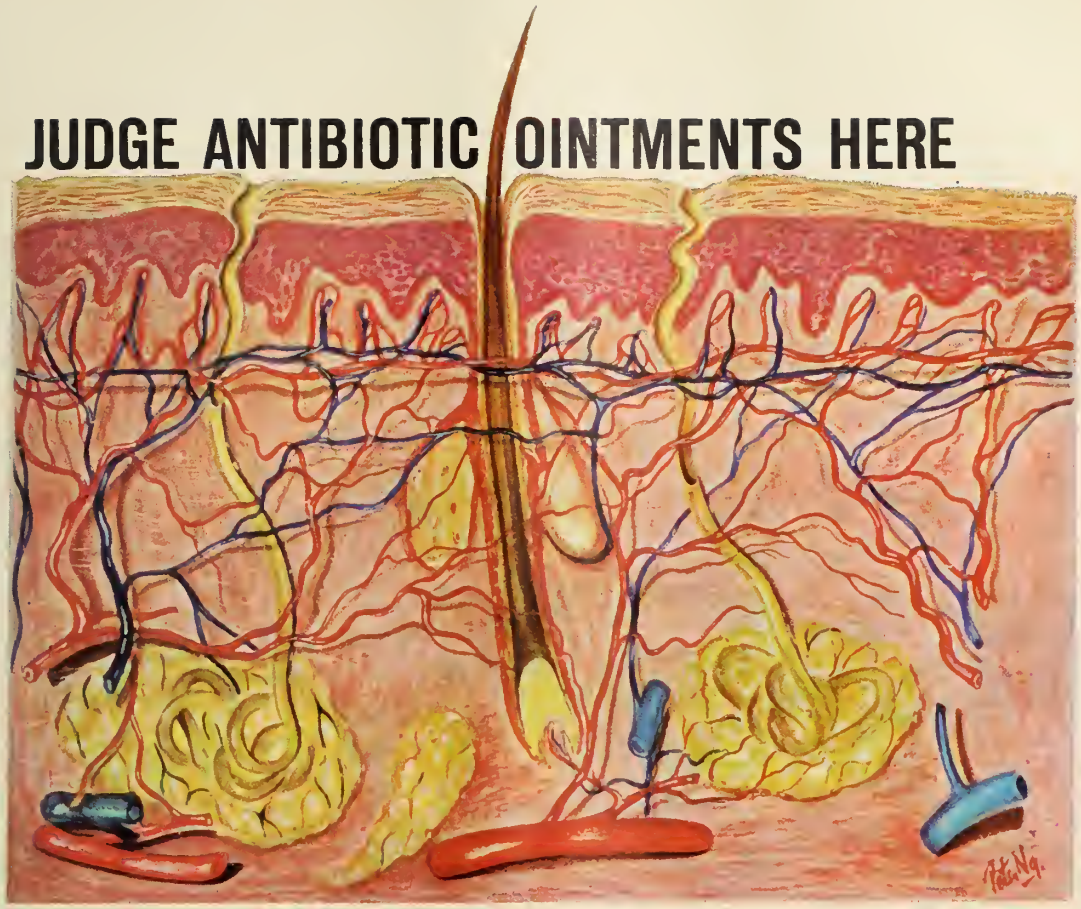
MEDICAL CENTER VICE CHAIRMAN

Dr. Harold W. Schnaper, who joined the faculty of the Medical College two years ago, has been named professor and executive vice chairman, Department of Medicine. Dr. Schnaper, who has published extensively in medical literature on such subjects as cardiovascular physiology, hypertension and large-scale clinical trials, has been serving as co-director of the Cardiovascular Research and Training Center.



Dr. Schnaper

JUDGE ANTIBIOTIC OINTMENTS HERE



Results on skin are final proof of any topical antibiotic's effectiveness

No in vitro test can duplicate a clinical situation on living skin. 'Neosporin' (polymyxin B—bacitracin—neomycin) Ointment has consistently proven its effectiveness in thousands of cases of bacterial skin infection. The spectra of the three antibiotics overlap in such a way as to provide bactericidal action against most pathogenic bacteria likely to be found topically. Diffusion of the antibiotics from the special petrolatum base is rapid since they are insoluble in the petrolatum, but readily soluble in tissue fluids. The Ointment is bland and nonirritating.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

Supplied: Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip.

Complete literature available on request from Professional Services Dept. PML.

'NEOSPORIN'®

brand

POLYMYXIN B-BACITRACIN-NEOMYCIN OINTMENT

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

Mild ulcerative colitis may be triggered here...



In mild ulcerative colitis, a number of factors can precipitate an attack: for instance, dietary indiscretion, such as eating raw foods, or emotional overreaction, such as that aroused by financial difficulties. No matter what causes the patient's sensitive colon to "act up," he soon suffers from acute discomfort...and often, from anxiety and apprehension as well. Such patients frequently respond well to adjunctive dual-action Librax® therapy.

Librax combines, in a single convenient capsule, the well-known antianxiety effect of Librium® (chlordiazepoxide HCl) and the dependable anticholinergic/antispasmodic effect of Quarzan® (clidinium Br). Therefore, as Librax helps to relieve the patient's excessive anxiety and reduce his overreaction to stress, it also, at the same time, helps to control hypersecretion and hypermotility, thus relieving spasm and abdominal discomfort.

With Librax, the dosage schedule is simple: 1 or 2 capsules, t.i.d. or q.i.d., will in most cases bring the patient significant relief of both the emotional and physical elements that contribute to his psychovisceral disorder.

Before prescribing, please consult complete product information, a summary of which follows.

INDICATIONS: Indicated as adjunctive therapy to control emotional and somatic factors in gastrointestinal disorders.

CONTRAINDICATIONS: Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide HCl and/or clidinium bromide.

WARNINGS: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering Librium (chlordiazepoxide hydrochloride) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards. As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

PRECAUTIONS: In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and toler-

or here.



ated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

ADVERSE REACTIONS: No side effects or manifestations not seen with either compound alone have been reported with Librax. When chlordiazepoxide hydrochloride is used alone, drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver-function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics, and/or low residue diet.

two good reasons for prescribing LIBRAX®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

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Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110



Nose clear as a whistle

(THANKS TO DIMETAPP®)

Dimetapp Extentabs® does an outstanding job of helping to clear up the stuffiness, drip and congestion of colds and upper respiratory allergies and infections. Each Extentab keeps working up to 12 hours. And for most patients drowsiness or overstimulation is unlikely. Try Dimetapp. It clearly works.

FOR UPPER RESPIRATORY ALLERGIES AND INFECTIONS

Dimetapp Extentabs®

Dimetane® (brompheniramine maleate), 12 mg.; phenylephrine HCl, 15 mg.; phenylpropanolamine HCl, 15 mg.

UP TO 12 HOURS CLEAR BREATHING ON ONE TABLET

Indications: Dimetapp is indicated for symptomatic relief of the allergic manifestations of respiratory illnesses, such as the common cold and bronchial asthma, seasonal allergies, sinusitis, rhinitis, conjunctivitis, and otitis.
Contraindications: Hypersensitivity to antihistamines. Not recommended for use during pregnancy.
Precautions: Until patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension.
Side Effects: Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia, have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered.
Dosage: 1 Extentab morning and evening.
Supplied: Bottles of 100 and 500.

A.H. ROBINS COMPANY
RICHMOND, VA. 23220

A·H·ROBINS

One Of Alabama's 23 Flying Doctors Going To Lake Placid

Airplane pilots generally carry along a first aid kit on their flights into the wild blue yonder. But only 23 of all the licensed pilots in Alabama have aboard a more elaborate bag of pills and medication, stethoscope, hyperdermic needles, surgical instruments and all the items customarily found in the bag of the busy doctor.

And only one of Alabama's 23 members of the Flying Physicians Association had formed plans, when this was written, to attend the annual meeting at Lake Placid.



He is Dr. George W. F. Singleton, of Selma, who is in general practice and surgery when he is not aloft in his Bonanza. And a fellow flying enthusiast is his wife, the former Minnie Johnson of Selma, who will fly with him to Lake Placid. In the accompanying picture, Mrs. Singleton is standing on the wing of the plane.

The Singletons' three children: George, 20; Ann, 16; Jean, 13; will not accompany them on this trip. Nor will the rest of the family, consisting of two dogs and one horse.

Born Oct. 9, 1918 at Rocky Mount, N. C. (when the author of this article, incidentally, was aboard a Marine troop transport enroute to France in World War I), Dr. Singleton was graduated from Duke with a baccalaureate degree in 1940, with his medical degree in 1943, and interned the following year at Duke Hospital. His surgical residency was served at the Henry Ford Hospital, Detroit.

A certified FAA medical examiner, the flying doctor is a member of the American Board of Surgery, the American College of Surgeons, the Southeastern Surgical Congress, the AMA and MASA.

The Flying Physicians Association lists 22 other members in Alabama, nine from Birmingham: Drs. B. E. Blankenship, Don Bryan, Lewis S. Chase, Charles B. Crow, Peter B. Hukill, Edward D. Miller, Richard B. Shepard, E. W. Stevenson and Chauncey B. Thuss; three from Decatur: Sidney B. Chenault, Troy F. Kilpatrick and Claude W. Lavender; two from Mobile: Leland L. Brown and Robert H. Mudd; two from Selma: Singleton and Garrell C. Noah; and one each from: Anniston, T. C. Donald, Jr.; Greensboro, Chester E. Singleton; Huntsville, John W. Reece; Montgomery, Paul D. Everest; Pell City, Horace C. Clayton; Phenix City, V. Woodard Corder; and Russellville, Ralph O. Underwood.

Internist and General Practitioner needed in growing North Central Alabama town of 45,000 on Tennessee River. Well diversified industry. Excellent schools. Associate with two physicians with established practice. New office space available two blocks from accredited hospital.

Contact
J. M. MILLER, SR., M. D.
1107 16th Ave., S. E.
Decatur, Alabama 35601

What makes a

A man?
Another woman?
Three kids?
No kids at all?
Wrinkles?
You name it.

Is she truly depressed?

Is that why she lets go in your office?

You comfort her.
Talk to her.
And, if she is depressed, consider Pertofrane.
Because
in 3 to 5 days
she can often begin
to cope,
work,
maybe play,
even enjoy.

Pertofrane®

desipramine hydrochloride
In depression...
when words are not enough

But before you prescribe Pertofrane, please see the full prescribing information and especially note Contraindications, Precautions, Warning, Adverse Reactions and Dosage. A brief summary of that information is included here.

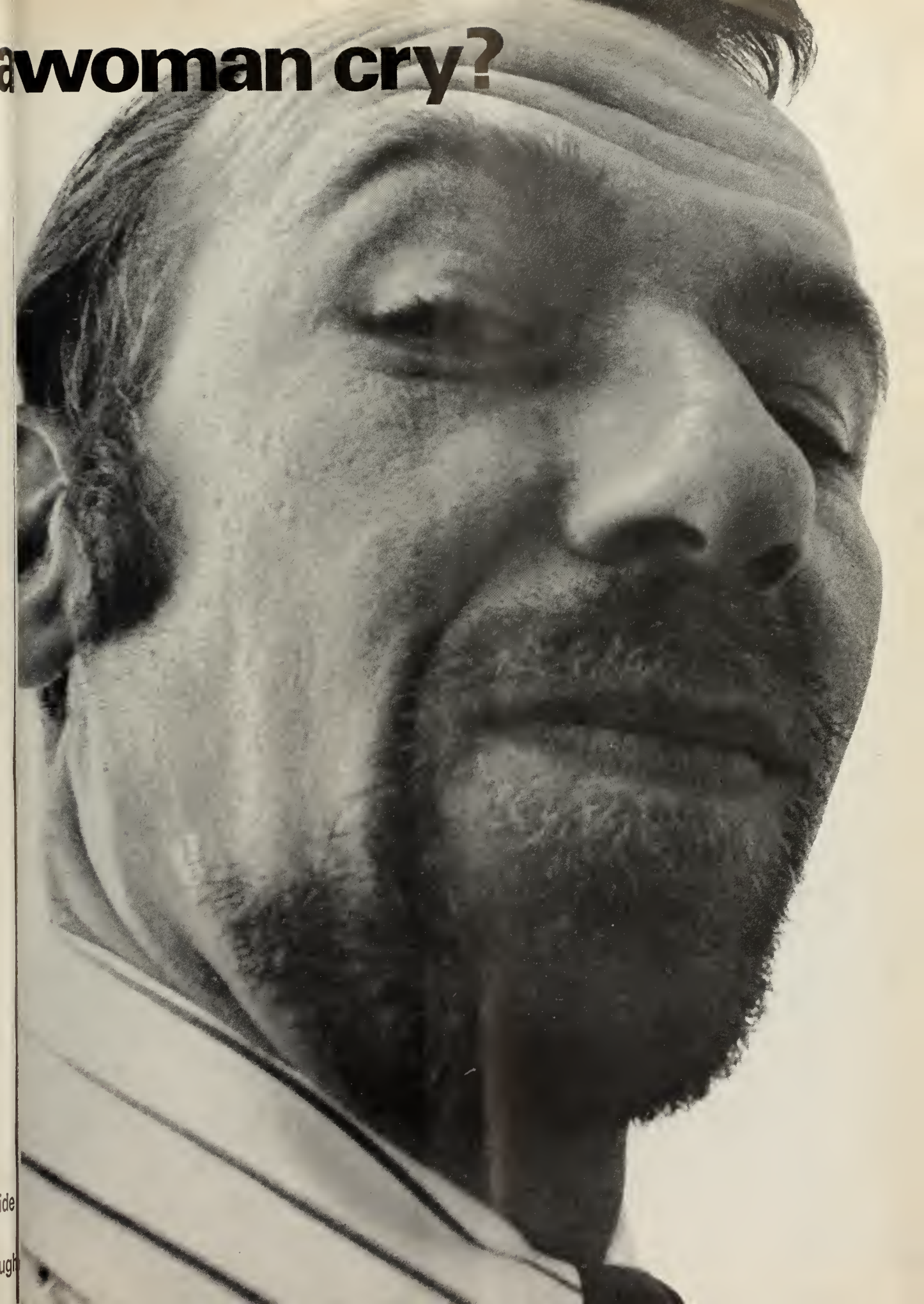
Pertofrane® desipramine hydrochloride

Indications: For relief of depression.
Contraindications: Do not use drugs of the M.A.O.I. class with Pertofrane. Hyperpyretic crises or severe convulsive seizures may occur; potentiation of adverse effects can be serious or even fatal. When substituting this drug in patients receiving an M.A.O.I., allow an interval of at least 7 days. Initial dosage in such patients should be low and increases should be gradual and cautiously prescribed.
Warning: Activation of psychosis may occasionally be observed in schizophrenic patients. Do not use in patients under 12 years old, and do not use in women who are or may become pregnant unless the clinical situation warrants the potential risk.
Precautions: Careful supervision and protective measures for potentially suicidal patients are necessary. Discontinuation of therapy or adjunctive use of a sedative or tranquilizer may be necessary in the presence of increased anxiety or agitation, hypomania or manic excitement. However, phenothiazines may aggravate the condition. Atropine-like effects may be more pronounced (e.g. paralytic ileus) in susceptible patients and in those receiving anticholinergic drugs (including antiparkinsonism agents). Carefully observe patients with increased intraocular pressure. Prescribe cautiously in hyperthyroid patients and in those receiving thyroid medications. Cardiovascular complications (myocardial infarction and arrhythmias) are potential risks since they have occasionally occurred with imipramine, the parent compound. Desipramine may block the pharmacologic activity of guanethidine and related adrenergic neuron-blocking agents. Hypertensive episodes have been observed during surgery in patients on desipramine therapy.
Before prescribing the drug, the physician should be thoroughly familiar with prescribing information, with the literature, with all adverse reactions, with the diagnosis and management of depression, and with the relative merits of all measures for treating the condition.
Adverse Reactions: Dry mouth, constipation, disturbed visual accommodation, anorexia, perspiration, insomnia, drowsiness, dizziness, headache, nausea, epigastric distress, and skin rash (including photosensitization) may appear. Since orthostatic hypotension has occurred, carefully observe patients requiring concomitant vasodilating therapy, particularly during the initial phases. Other adverse reactions include tachycardia, changes in EEG patterns, tremor, falling, mild extrapyramidal activity, neuromuscular incoordination, epileptiform seizures. A confusional state (with such symptoms as hallucinations and disorientation) occurs occasionally and may require reduced dosage or discontinuance of therapy. Rarely, transient eosinophilia, slight elevation in transaminase levels, transient jaundice, or liver damage have occurred. If abnormalities occur in liver function tests, discontinue drug and investigate. Occasional hormonal effects, particularly decreased libido or impotence and instances of gynecomastia, galactorrhea and female breast enlargement have been observed. Urinary frequency or retention may occur. The drug should be discontinued if agranulocytosis, bone marrow depression, jaundice, thrombocytopenia, or purpura occur.
Dosage: 25 to 50 mg t.i.d. The maximum daily dose is 200 mg. Continue maintenance dosage for at least 2 months after obtaining satisfactory response. Generally, elderly and adolescent patients should be given low doses.
Availability: Pink capsules of 25 mg in bottles of 100 and 1000. (B) 46-530-E

For complete details, please see the prescribing information.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

a woman cry?





Nixon Bill Puts Tourniquet on Hill-Burton Funnel To Alabama

Across its 21 years of history, Federal largess has poured nearly $108 million into Alabama hospitals, public health centers, nursing homes, tuberculosis sanitoria and dental clinics, through the Hill-Burton funnel. Beds for patient care have increased by 11,855.

Within the next month there is a grave danger that this funnel will become so completely clogged that not one penny will leak through to public, non-profit hospitals in Alabama, ever again, according to the interpretation of Clay Dean, director, Bureau of Health Facilities Construction, State Health Department. Public, non-profit hospitals represent the topheavy majority of such facilities in this state.



Clay Dean

Shortly after taking office, President Nixon issued a directive to HEW Secretary Robert H. Finch to make "a reevaluation of the Hill-Burton Act and a new set of recommendations concerning federal aid for the construction of community and other health facilities."

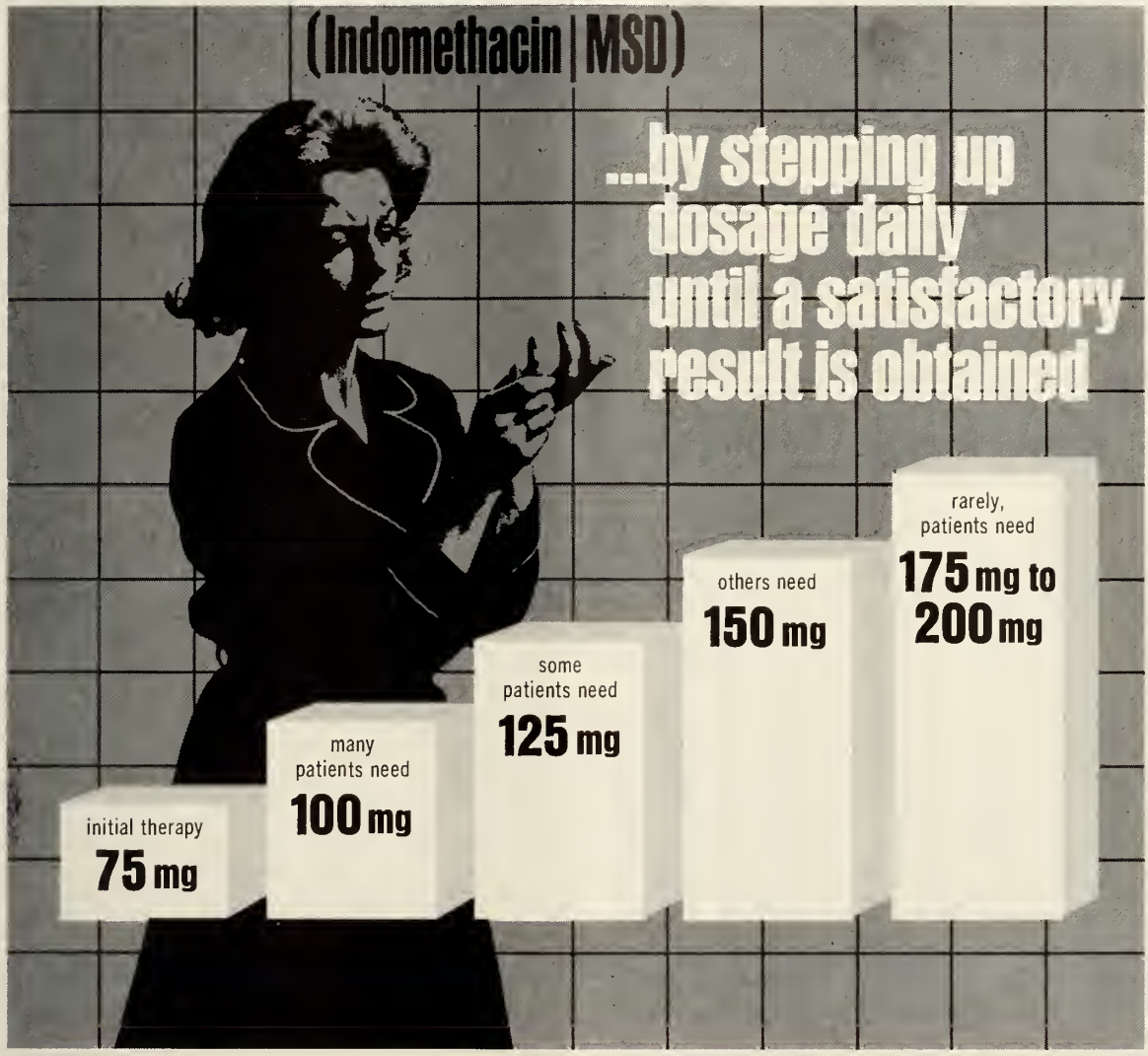
Two multibillion-dollar construction and modernization bills were introduced in Congress, one by Chairman Harley O. Staggers of the House Interstate and Foreign Commerce Committee, the other by Rep. Paul G. Rogers of Florida, both Democrats. And because the latter would *deny* construction or modernization assistance to a general hospital except with extended-care strings attached to it, and because this bill would "drop the squaring factor under which low income states receive proportionately more funds from Hill-Burton grants than higher income states," the Staggers bill won prompt applause from states other than the Big Few. Notably it had the approval of ASTHO (Association of State and Territorial Health Officers).

After the hearings were held, an administration bill was introduced into the Senate by Senator Javits (R), New York, setting up a sort of FHA loan program for hospitals and health facilities, incorporating the features of the Rogers bill to which Alabama

(Continued on Page 1141)

In selected cases of rheumatoid arthritis with acute symptoms

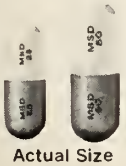
Response to INDOCIN® is often improved...



Many patients with acute rheumatoid arthritis or acute episodes of chronic rheumatoid arthritis can be controlled by increasing the dosage 25 mg *per day* (to the allowable maximum) until the episode subsides; the dosage should then be reduced gradually to maintenance levels. Few require the maximum (175–200 mg).

In the event the patient develops adverse effects, dosage should be reduced to tolerated levels for 2 or 3 days and then gradually increased by 25 mg every few days as tolerated. G.I. effects may be minimized by giving INDOCIN with food, antacids, or immediately after meals.

Now in two strengths
25 mg and 50 mg



Actual Size

INDOCIN®
(Indomethacin | MSD)

IMPORTANT NOTE: INDOCIN (Indomethacin, MSD) cannot be considered a simple analgesic and should not be used in conditions other than those recommended under *Indications*. The drug should not be prescribed for children because safe conditions for use have not been established.

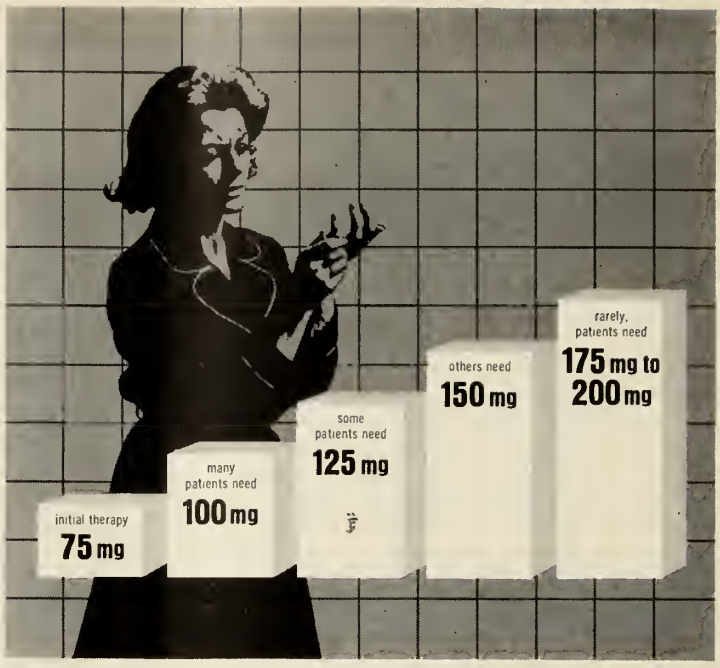
CONTRAINDICATED:

- in aspirin-sensitive asthmatics
- during pregnancy or lactation
- in children
- INDOCIN may mask the signs and symptoms of peptic ulcer and may cause ulceration or irritation of the G.I. tract. Therefore, do not give in active peptic ulcer, gastritis, regional enteritis, ulcerative colitis, and use with caution if there is a history of these disorders.

For additional prescribing information, please see following page.

In selected cases
of rheumatoid arthritis
with acute symptoms

Response to INDOCIN® (Indomethacin | MSD) is often improved by stepping up dosage daily until a satisfactory result is obtained



IMPORTANT NOTE: INDOCIN (Indomethacin, MSD) cannot be considered a simple analgesic and should not be used in conditions other than those recommended under Indications. The drug should not be prescribed for children because safe conditions for use have not been established.

Indications: For the symptomatic treatment of rheumatoid arthritis, rheumatoid (ankylosing) spondylitis, degenerative joint disease (osteoarthritis) of the hip, and gout.

Contraindications: INDOCIN may mask the signs and symptoms of peptic ulcer and may itself cause peptic ulceration or irritation of the G.I. tract. For these reasons it should not be given to patients with active peptic ulcer, gastritis, regional enteritis, or ulcerative colitis (use with caution if there is history of these disorders); aspirin-sensitive asthmatics. Safe use during pregnancy or during lactation has not been established. Should not be prescribed for children because safe conditions for use have not been established. In a few cases of severe juvenile rheumatoid arthritis receiving INDOCIN along with other drugs, severe reactions, including fatalities, have been reported.

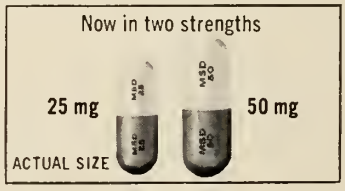
Warnings: Patients who experience dizziness, lightheadedness, or feelings of detachment on INDOCIN should be cautioned against operating motor vehicles or machinery, climbing ladders, etc. Use cautiously in patients with psychiatric disturbances, epilepsy, or parkinsonism since it may aggravate these conditions.

Precautions: Use cautiously in patients with a history of peptic ulcer, gastritis, regional ileitis, or ulcerative colitis because of its potential for causing G.I. bleeding. May cause single or multiple ulceration of the esophagus, stomach, duodenum, or small intestine, and, in a few instances, severe bleeding and perforation with a few fatalities have been reported. May potentiate the ulcerogenic effect of steroids, salicylates, or phenylbutazone. Gastrointestinal bleeding with no obvious ulcer formation has also been noted; the drug should be discontinued if G.I. bleeding occurs. As a result of obvious or occult G.I. bleeding, some patients may manifest anemia, and for this reason periodic hemoglobin determinations are recommended. G.I. effects may be minimized by giving the drug with food or with antacids or immediately after meals. In common with other drugs that have anti-inflammatory, analgesic, and antipyretic properties, indomethacin may mask the signs and symptoms of infection; avoid undue delay in initiating appropriate treatment of the infection; use cautiously in patients with existing, but controlled, infections. As with any new drug, patients should be followed carefully to detect unusual manifestations of drug sensitivity.

Adverse Reactions: Starting therapy with low doses, with gradual increases when necessary, will minimize adverse reactions. *Central Nervous System:* Most commonly, headache (usually more severe in morning), dizziness, and lightheadedness; infrequently observed reactions include mental confusion, drowsiness, convulsions, coma, depression, and other psychic disturbances, such as depersonalization; CNS effects are often transient and frequently disappear with continued treatment or reduced dosage. The severity of these effects may occasionally require cessation of therapy. *Gastrointestinal:* Most commonly, nausea, anorexia, vomiting, epigastric distress, abdominal pain, and diarrhea; others that may develop are ulceration, single or multiple, of esophagus, stomach, duodenum, or small intestine, including perforation and hemorrhage with a few fatalities having been reported; G.I. bleeding without obvious ulcer formation, increased abdominal pain in patients with preexisting ulcerative colitis; less commonly, stomatitis; gastritis; bleeding from the sigmoid colon, occult in type or from a diverticulum, and perforation of preexisting sigmoid lesions (diverticulum, carcinoma); G.I. reactions not known definitely to be attributable to indomethacin include development of ulcerative colitis and of regional ileitis. *Hepatic:* Rarely, jaundice and hepatitis. *Cardiovascular-Renal:* Infrequently, edema, elevation of blood pressure, and hematuria. *Dermatologic-Hypersensitivity:* Infrequently, pruritus, urticaria, angioneurotic edema, angiitis, skin rashes, loss of hair, and acute respiratory distress including sudden dyspnea and asthma. *Hematologic:* Infrequently, leukopenia, purpura, and thrombocytopenia; rarely, agranulocytosis and bone marrow depression have been reported, but a definite relationship to the drug has not been established; since some patients may manifest anemia secondary to obvious or occult G.I. bleeding, periodic hemoglobin determinations are recommended. *Eye-Ear:* Infrequently, tinnitus, blurred vision, hearing disturbance, and orbital and periorbital pain. *Miscellaneous:* Rarely, vaginal bleeding, hyperglycemia, and glycosuria.

Supplied: Capsules containing 25 mg indomethacin each, in bottles of 100 and 1000; capsules containing 50 mg indomethacin each, in bottles of 100.

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WHERE TODAY'S THEORY IS TOMORROW'S THERAPY

(Continued from Page 1138)

and many other states, in varying degrees, object.

The Javits bill would close out the current Hill-Burton program this month and substitute a mortgage-guarantee program available to private, non-profit hospitals only.

Doubtless out of deference to the co-author of the bill, the senior Senator from Alabama, the first beneficiary of Hill-Burton funds on record in the United States was the George H. Lanier Memorial Hospital at Langdale, approved a dozen years ago, providing for 87 beds, at a total cost of $2,160,398, of which the federal government's share was $719,009.

Projects No. 2 and 3, No. 6 and 7, appropriately enough were Birmingham facilities: Jefferson County Public Health Center, Carraway Methodist, the Crippled Children's Clinic and St. Vincents, in that order on the Computer list. Through 1968, Jefferson was the largest recipient of federal money under the Hill-Burton program with $16,773,721.

Mobile is next in the total federal benefactions, with $14,598,513. It was also No. 5 in the roll call of projects, with federal funds of $195,475 going to the total cost of $611,425 to provide 30 beds for St. Martin de Perres Hospital. The county's largest Hill-Burton allotment was $2,560,000 of federal money, as part of the $8,236,172 to provide 240 beds for Mobile General Hospital.

Montgomery ranks No. 3 in the State with federal money under the Hill-Burton bill totaling $7,117,371. St. Margaret's hospital, with federal benefactions for three projects totaling $3,009,268, is in first place; Montgomery Baptist second, with $1,000,000; St. Jude's third with two projects totaling $837,-962; and six other institutions dividing the balance: Montgomery County Health Center, the city-county charity clinic, Public Health Laboratories, the children's center, and the Tuberculosis Sanitarium and Central Alabama Rehabilitation Center with two projects each.

Specifically, the Javits bill terminates the Hill-Burton Act effective June 30, 1969; eliminates all grant programs for public and non-profit hospital construction; provides a loan guarantee program for private non-profit hospitals. In effect said Mr. Dean:

"This bill would be very detrimental to all hospitals in Alabama and particularly public hospitals, since they would get no help whatsoever from federal sources. Actually this bill (S. 1733) would kill the hospital construction program in Alabama and the nation. It would also kill a similar loan guarantee program under the Department of Housing and Urban Development."

This bill should be vigorously opposed.

In The Name of Diabetes



MRS. EDWARD L. NORTON of Birmingham has given $135,000 in memory of her husband to be used toward the cost of a Diabetes Hospital planned for the Medical Center of the University of Alabama in Birmingham. Mrs. Norton is shown with Mr. Pratt Rather, left, State Chairman of the Diabetes Hospital fund drive and Dr. J. F. Volker, Executive Vice President of the University of Alabama in Birmingham. Mr. Norton, who died in 1966, was one of Birmingham's most respected business and community leaders. At the time of his death he was Chairman of the Board of the Royal Crown Cola Company.

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July 1968-June 1969

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Warnings: USE IN PREGNANCY: Since safety of the use of this preparation in pregnancy, during lactation, or in the childbearing age has not been established, use of the drug in such patients requires that the potential benefits of the drug be weighed against its possible hazard to the mother and child.

USE IN CHILDREN: The safe and effective use of this drug in children has not been established; therefore, the physician must weigh the benefits against the potential hazards.

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Forensic Psychiatry Seminars Held At Smolian Psychiatric Clinic

Third-year psychiatric residents at Smolian Psychiatric Clinic were introduced to some legal aspects of their profession this spring during a series of seminars sponsored by the University of Alabama Medical School's Department of Psychiatry and Samford University's Cumberland School of Law.

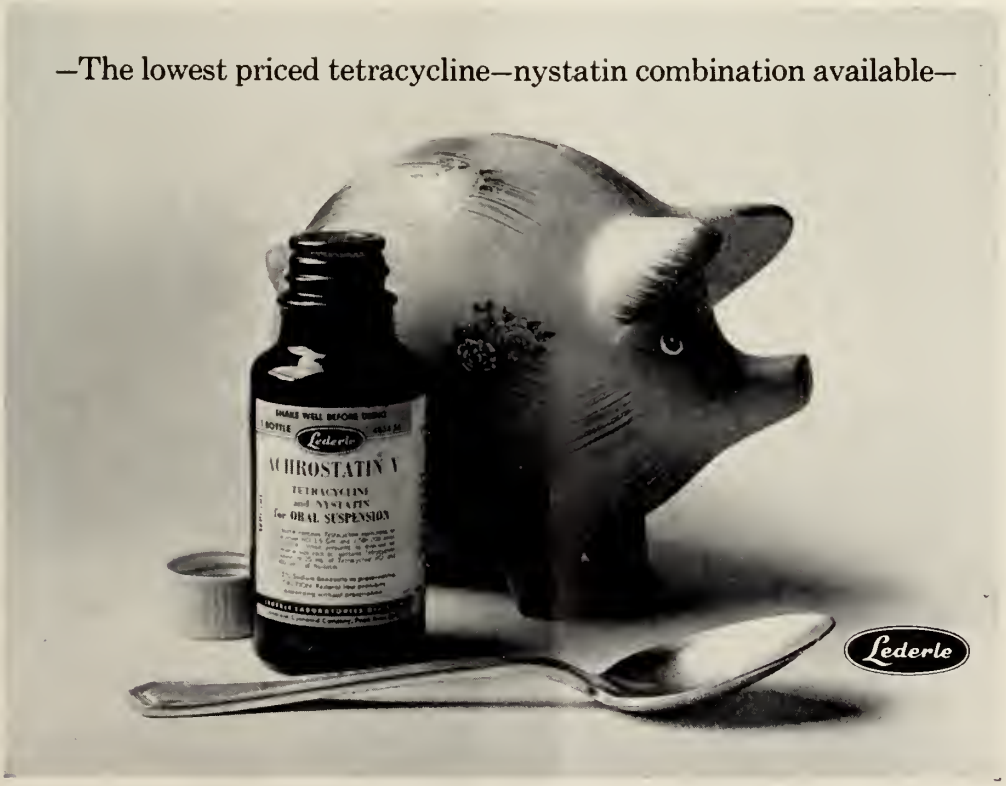
The program, conducted on an informal basis, was probably Alabama's first in forensic psychiatry, although the subject is not new in several other states.

Attorneys from the Birmingham area covered such subjects as the doctor-lawyer relationship in civil cases, the legal definition of privileged communication between physician and patient, procedures for committing patients to mental institutions, defense of malpractice suits, the jury system, and differences between legal and medical definitions of insanity.

Mrs. Janie Shores, assistant professor at Cumberland Law School, and Dr. George Palmer Turner, Jr., assistant professor of psychiatry at the Medical School, arranged the seminars. Both expressed hope that the program would be continued next year.

Although psychiatric residents participated in the current seminars, physicians in other specialties also often are called upon to appear in court, Mrs. Shores pointed out. An expanded knowledge of legal procedures by doctors would be beneficial to members of both the legal and medical professions, she said.

Seminars began March 18 and concluded June 4.



Convalescing . . . but still a long way to go. Anxiety can make it even longer.

Convalescence following medical or surgical procedures may be almost endless to an anxious patient. And, indeed, anxiety with some patients actually retards progress—for example, by inducing insomnia and reducing cooperation.

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Warn patients of possible reduced alcohol tolerance, with resultant slowing of reaction time and impairment of judgment and coordination.

Reduce dose if drowsiness, ataxia or visual disturbance occurs; if persistent, patients should not operate vehicles or dangerous machinery.

Side Effects include drowsiness, usually transient; if persistent and associated with ataxia, usually responds to dose reduction; occasionally concomitant CNS stimulants (amphetamine, mephentermine sulfate) are desirable. Allergic or idiosyncratic reactions are rare, but such reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Previous history of allergy may or may not be related to incidence of reactions. Mild reactions are characterized by itchy urticarial or erythematous maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically as with epinephrine, antihistamine and possibly hydrocortisone. Aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia have occurred rarely, almost always in presence of known toxic agents. A few cases of leukopenia, usually transient, have been reported on continuous administration.

Meprobamate may sometimes precipitate grand mal attacks in patients susceptible to both grand and petit mal. Extremely large doses can produce rhythmic fast activity in the cortical pattern. Impairment of accommodation and visual acuity has been reported rarely. After excessive dosage for weeks or months, withdraw gradually (1 or 2 weeks) to avoid recurrence of pretreatment symptoms (insomnia, severe anxiety, anorexia). Abrupt discontinuance of excessive doses has sometimes resulted in vomiting, ataxia, tremors, muscle twitching and epileptiform seizures. Prescribe very cautiously and in small amounts for patients with suicidal tendencies. Suicidal attempts have resulted in coma, shock, vasomotor and respiratory collapse and anuria. Excessive doses have resulted in prompt sleep; reduction of blood pressure, pulse and respiratory rates to basal levels; and occasionally hyperventilation. Treat with immediate gastric lavage and appropriate symptomatic therapy. (CNS stimulants and pressor amines as indicated.) Doses above 2400 mg./day are not recommended.

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Alabama Department of Public Health

Bus Serves Schools As Mobile Clinic

By Joyce Murphree

It looks like a school bus and is, in fact, a school bus with most of the seats removed. However, its function is not transportation of students but the transport of health services to Sumter County's more than 5,000 school children.

Equipped as a clinic for screening procedures, the mobile health unit is a joint venture of the Sumter County Health Department and the Sumter County Board of Education.

In its third year of operation, the bus was purchased by the Sumter County Board of Education. It is staffed by Mrs. Helene Upchurch, public health nurse, and Mrs. Janice Huffstetter, an aide. Salaries of both are provided from Title I funds, but they work under the supervision of Dr. S. J. Williams, county health officer.

Schools in Sumter County are severely overcrowded, caused partly by mandatory consolidation. There is no room to set up screening clinics in schools without disrupting classes. Dr. Williams conceived the idea of the mobile clinic to solve the space problem. The bus also conserves time by eliminating the need to transfer equipment from automobile to school building and back again.

The bus operates four days a week when school is in session. Each school is visited at least every two weeks and sometimes at one-week intervals. About 100-150 students are screened each day.



Mrs. Janice Huffstetter marshals Sumter County children aboard a school bus. This bus differs from most in that its principal function is not transportation. It serves as a mobile health clinic for youngsters.



The bus is equipped with a desk, which is useful in taking information for health records. Conferences with teachers are also held aboard the bus.



All elementary school children are routinely screened for hearing defects. Mrs. Helene Upchurch, public health nurse, operates the audiometer. In addition to her nursing duties, she is driver of the bus.

Children in the upper six grades of school are screened upon referral from teachers. Every child in grades one through six is screened for vision and hearing defects, dental caries, and growth. Immunizations and tuberculin skin tests are given; health-related films are shown; and teacher conferences are held on the bus. It was also used in the mass measles campaign and is used for pre-school clinics in the spring.

Dr. Williams believes the school bus-health clinic to be unique in Alabama. However, other counties have expressed an interest in the project, he said.

Should the project have to be discontinued for lack of funds or for any other reason, the bus could be converted to transportation use, simply by installing seats.



In addition to routine screening, nursing personnel give instruction in good health practices. Mrs. Upchurch demonstrates the proper method of brushing teeth.

Calendar of Annual Meetings

Medical Association of the State of Alabama

1970, April 30-May 2, Mobile

1971, April 22-24, Birmingham

1972, April 20-22, Montgomery

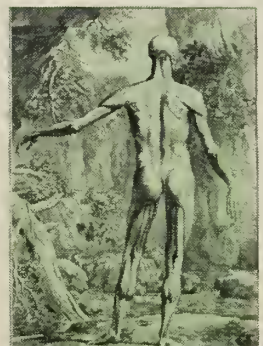
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BUREAU OF PREVENTABLE DISEASES

Frederick S. Wolf, M. D., Acting Director

Current Morbidity Statistics

1969

	March	April	*E.E. April
Tuberculosis	103	94	117
Syphilis	28	54	135
Gonorrhea	478	476	304
Cancroid	1	0	1
Typhoid fever	0	0	1
Salmonella	10	8	4
Undulant fever	0	0	0
Shigella	2	2	5
Amebic dysentery	0	0	4
Scarlet fever & strep. throat	654	453	151
Diphtheria	0	0	0
Whooping cough	4	0	8
Meningitis	5	6	6
Tularemia	0	0	0
Tetanus	0	0	1
Poliomyelitis	0	0	0
Encephalitis	0	0	0
Smallpox	0	0	0
Measles	0	0	430
German measles	42	17	15
Chickenpox	94	56	146
Mumps	36	27	92
Infectious hepatitis	41	53	43
Typhus fever	0	0	0
Malaria	1	0	0
Cancer	1,273	690	662
Pellagra	0	0	0
Rheumatic fever	8	16	18
Rheumatic heart	23	17	28
Influenza	1,707	733	376
Pneumonia	541	450	334
Rabies—Human cases	0	0	0
Pos. animal heads	8	9	0

As reported by physicians and including deaths not reported as cases.

*E.E.—The estimated expectancy represents the median incidence of the past nine years.

Calendar of Annual Meetings

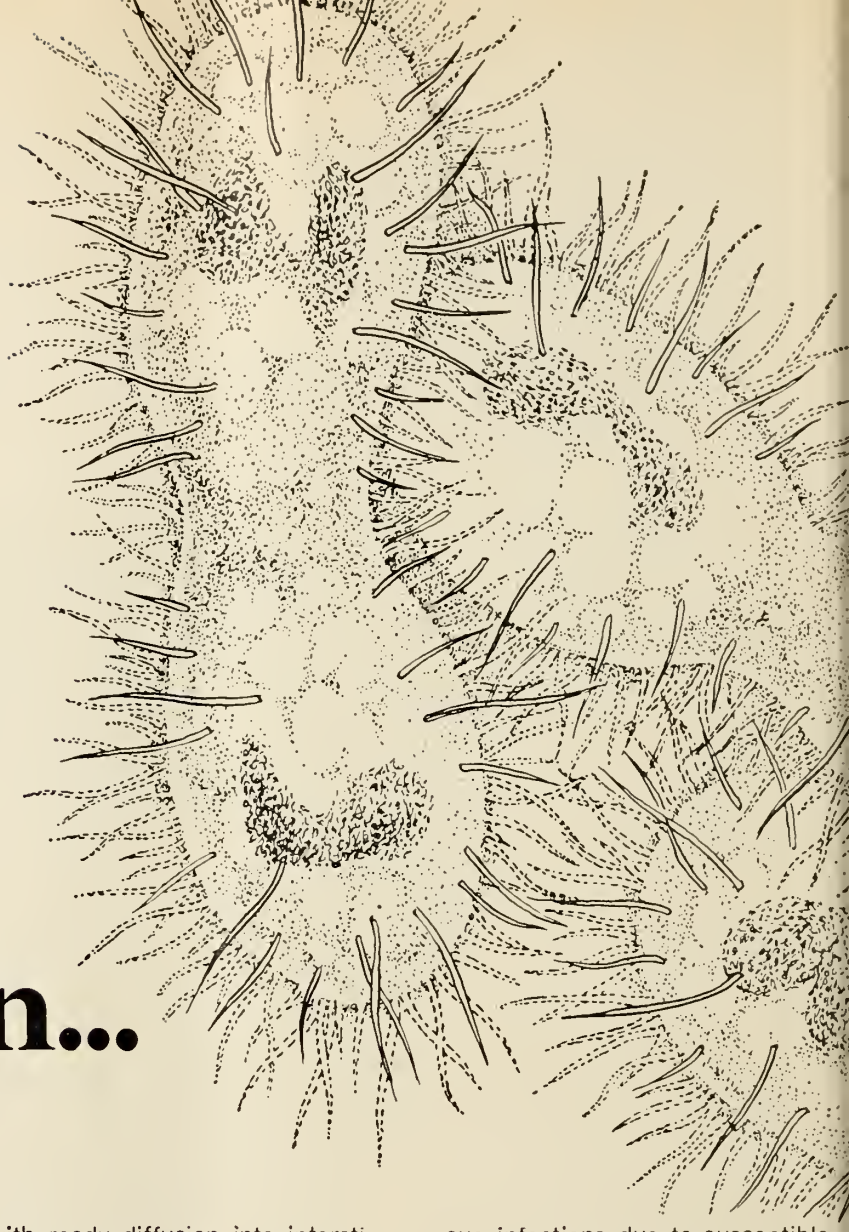
Medical Association of the State of Alabama

1970, April 30-May 2, Mobile

1971, April 22-24, Birmingham

1972, April 20-22, Montgomery

1973, April 18-21, Mobile



A high index of suspicion... E. coli

How high is the "index of suspicion" for *E. coli* in urinary tract infections?

Recently it has been estimated that about 86 per cent of positive cultures in first attacks of urinary tract infection are *E. coli*.[1] It has also been noted that "The coliform group, especially *E. coli*, accounts for approximately 90 per cent of initial infections...."[2]

Consider wide-spectrum Gantanol® (sulfamethoxazole) for its high "index of confidence"—its proven effectiveness against *E. coli* and other sensitive gram-negative and gram-positive organisms. Therapeutic levels of Gantanol in blood and urine are achieved within 2 hours after a 2-Gm starting dose, with ready diffusion into interstitial fluids. Responsive infections generally clear within 5 to 7 days, with relief of symptoms usually seen within 24-48 hours.

Gantanol also earns its high "index of confidence" because Gantanol therapy is relatively free from complications, including the problem of bacterial resistance or superinfection.

Convenient, economical dosage schedule: *b.i.d.*

References: 1. Vernier, R. L., in Patient Care Feature: *Patient Care, 1*:20 (Feb.) 1967. **2.** Beeson, P. B.: "The Infectious Diseases," in Beeson, P. B., and McDermott, W. (eds.): *Cecil-Loeb Textbook of Medicine*, ed. 12, Philadelphia, W. B. Saunders Company, 1967, p. 230.

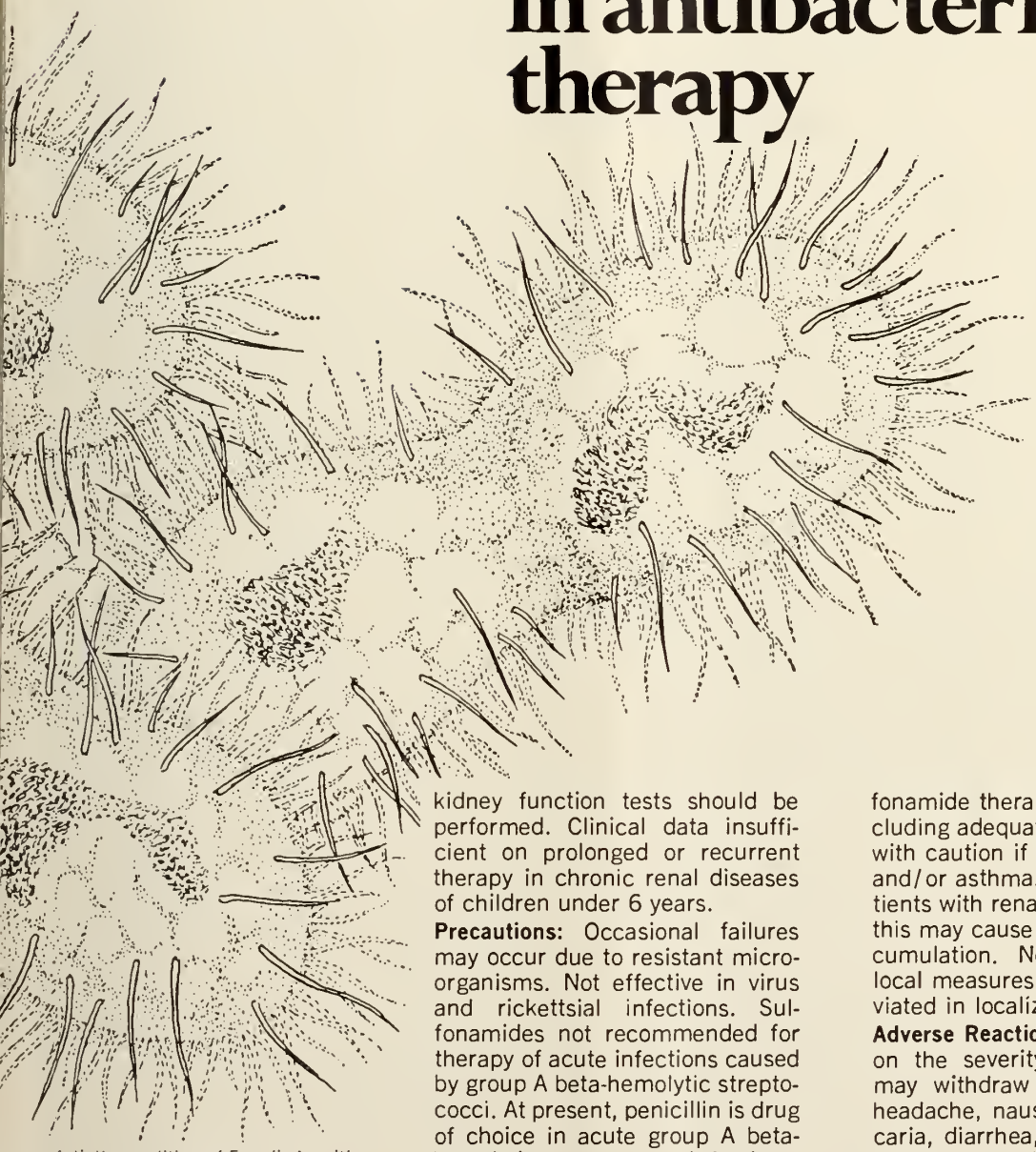
Before prescribing, please consult complete product information, a summary of which follows:

Indications: Acute and chronic urinary tract, respiratory and soft tissue infections due to susceptible microorganisms; prophylactically following diagnostic instrumental procedures on genitourinary tract.

Contraindicated in sulfonamide-sensitive patients, pregnant females at term, premature infants, or newborn infants during first 3 months of life.

Warnings: Use only after critical appraisal in patients with liver or renal damage, urinary obstruction or blood dyscrasias. Deaths reported from hypersensitivity reactions, Stevens-Johnson syndrome, agranulocytosis, aplastic anemia and other blood dyscrasias. In closely intermittent or prolonged therapy, blood counts and liver and

For a high index of confidence... Gantanol® (sulfamethoxazole) in antibacterial therapy



Artist's rendition of E. coli. As with most strains of E. coli, these have flagella and are motile.

kidney function tests should be performed. Clinical data insufficient on prolonged or recurrent therapy in chronic renal diseases of children under 6 years.

Precautions: Occasional failures may occur due to resistant microorganisms. Not effective in virus and rickettsial infections. Sulfonamides not recommended for therapy of acute infections caused by group A beta-hemolytic streptococci. At present, penicillin is drug of choice in acute group A beta-hemolytic streptococcal infections; although Gantanol has produced favorable bacteriologic conversion rates in this infection, data insufficient on long-term follow-up studies as to its effect on sequelae of rheumatic fever or acute glomerulonephritis. If other treatment cannot be used and Gantanol is employed in such infections, *important that therapy be continued in usual recommended dosage for at least 10 days.* Observe usual sulfonamide therapy precautions, including adequate fluid intake. Use with caution if history of allergies and/or asthma. Follow closely patients with renal impairment since this may cause excessive drug accumulation. Need for indicated local measures or surgery not obviated in localized infections.

Adverse Reactions: Depending upon the severity of the reaction, may withdraw drug in event of headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, Stevens-Johnson syndrome, skin rash, injection of the conjunctiva and sclera, petechiae, purpura, hematuria and crystalluria.

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BUREAU OF VITAL STATISTICS
PROVISIONAL BIRTH AND DEATH STATISTICS AND COMPARATIVE DATA

Ralph W. Roberts, M. S., Director

February 1969

Live Births Deaths Causes of Death	Number Recorded During February 1969			Rates* (Annual Basis)		
	Total	White	Non-White	1969	1968	1967
Live Births	4,685	3,135	1,550	16.8	17.2	19.3
Deaths	2,572	1,702	870	9.2	9.8	9.3
Fetal Deaths	90	46	44	18.8	15.7	16.4
Infant Deaths						
under one month	75	44	31	16.0	18.6	15.2
under one year	137	63	74	29.2	29.0	28.0
Maternal Deaths	1	.....	1	2.1	2.0	3.7
Causes of Death						
Bacillary dysentery, amebiasis, 004, 006	.....	.....	.....	.....	.....	.....
Enteritis, other diarrheal diseases, 008, 009	10	2	8	3.6	†	†
Tuberculosis, all forms, 010-019	14	7	7	5.0	6.3	6.2
Diphtheria, 032	.....	.....	.....	.....	0.4	.....
Whooping cough, 033	.....	.....	.....	.....	.....	0.4
Meningococcal infections, 036	4	2	2	1.4	0.7	1.1
Poliomyelitis, (acute), 040-043**	.....	.....	.....	.....	.....	.....
Measles, 055	.....	.....	.....	.....	.....	0.4
Syphilis, 090-097	.....	.....	.....	.....	2.1	1.8
Malignant Neoplasms, 140-209	353	255	98	126.2	131.3	125.9
Diabetes Mellitus, 250	52	30	22	18.6	22.4	16.8
Major cardiovascular diseases, 390-448	1,238	856	382	442.7	†	†
Diseases of heart, 390-398, 402, 404, 410-429	809	596	213	289.3	326.4	319.4
Rheumatic fever & heart, 390-398	10	9	1	3.6	†	†
Hypertensive heart & renal diseases, 402, 404	31	17	14	11.1	†	†
Ischemic heart disease, 410-414	679	513	166	242.8	†	†
Cerebrovascular disease, 430-438	333	211	122	119.1	139.4	112.7
Diseases of the arteries, 440-448	75	45	30	26.8	25.6	24.1
Influenza, 470-474	31	24	7	11.1	8.4	0.7
Pneumonia, 480-486	115	64	51	41.1	39.6	32.6
Bronchitis, emphysema, asthma, 490-493	43	34	9	15.4	†	†
Appendicitis, 540-543	3	2	1	1.1	0.4	0.4
Hernia, intestinal obstr., 550-553, 560	9	7	2	3.2	3.9	2.9
Cirrhosis of liver, 571	17	15	2	6.1	5.6	6.6
Complications of preg., childbirth, 630-678	1	.....	1	2.1	2.0	3.7
Congenital anomalies, 740-759	23	16	7	4.9	4.5	5.3
Immaturity, 777	20	10	10	4.3	5.3	3.4
Accidents, total, 800-949	176	117	59	62.9	62.7	78.7
Motor Vehicle accidents, 810-823, 940	91	68	23	32.5	28.4	36.6
All other defined causes	315	202	113	112.6	124.0	126.6
Symptoms & ill-defined, 780-796	148	59	89	52.9	56.7	48.7

*Rates: Births and deaths—per 1,000 population
Infant deaths—per 1,000 live births
Fetal deaths—per 1,000 deliveries
Maternal deaths—per 10,000 deliveries
Deaths from specified causes—per 100,000 population

**Does not include late effects

†The Eighth Revision of ICD (New Revised Code) is used beginning with January 1969. Comparison with statistics compiled under the former Code (Seventh Revision ICD) and rates cannot be made. Direct to the Alabama Bureau of Vital Statistics any question about comparability of statistics compiled and rates under the new vs. the former ICD.

Emergency Physicians Formed Into An American Specialty

It takes all kinds of folks to people the emergency wards in American hospitals:

There are the victims of the tearing automobile crash, their bones broken, their bodies battered and torn, and probably suffering from hurts that show nowhere on the surface. There are the victims of guns and knives, the victims of poison, the victims of burns.

In this day of specialization, experience in this field of work is an asset that should not be overlooked.

As of now, the American College of Emergency Physicians has its officers centered largely in the state of its birth—Michigan, including Dr. John G. Wiegenstein, chairman of the board of directors; Dr. John T. Rogers, treasurer and executive director; and seven of the 14 members of the board of directors. Other states represented on the board are Florida, Missouri, Nebraska and Virginia, along with Washington, D. C.

Twenty-one of the fifty states have representation in the ACEP. In Region V, the East South Central Region, Kentucky and Tennessee are represented, Alabama and Mississippi thus far are not.

Inquiries may be addressed to the American College of Emergency Physicians, 120 W. Saginaw, East Lansing, Michigan 48823.

Professional Golf Pitch

W. L. Whiting, III

The golf equipment industry has grown at ten per cent annually over the past five years, while the Professional Golf Company of Chattanooga has driven straight down the fairway at an average 20 to 25 per cent annual clip.

President and chief executive Ralph Thompson is responsible for much of this growth. He joined the company in 1966 to straighten out various management difficulties. A veteran in the golf industry for over 25 years, he had headed the manufacturing division of Rawlings Sportings Goods.

Pro Golf was founded in 1931 as a manufacturer of clubs while a separate company, eventually titled First Flight after the producer's brand name, sold the equipment on a strictly pro shop basis. The two companies were separate entities but were essentially run by the same management.

Through the years, Pro Golf grew in size and reputation, but when Ralph Thompson took over, it was still very much a small "country club" operation with sales less than $5,000,000 and rather slim profit margins. The experienced new president moved the company into a new growth pattern. Since 1965 Pro Golf sales have doubled while profits have nearly tripled. For the 12 months ending September, 1968, sales reached $9,460,000 and profits $466,000 or 28c a share adjusted for a three for two split last December. In the December, 1967, year sales were $7,420,000 and profits $368,000 or 22c a share. Profits for the September fiscal years are estimated 80-85.

Comparisons are difficult not only because of the shift in fiscal years, but because of acquisitions. The September 1968, but not the 1967 figures, reflect last November's purchase of Willow Walnut. A manufacturer of wooden trophies and plaques plus trophy bases, Willow was a Thompson family enterprises and is run by Ralph Thompson's son. Included in neither 1967 nor September, 1968, figures was the major acquisition last December of Dodge Incorporated, another trophy maker, plus some minor subsequent additions.

In continuing its trend of making acquisitions related to its own product line Pro Golf earlier this year acquired two small companies both in the $1,000,000 sales area. They were Toney Penna which makes high quality golf clubs and Nylon Fabricators which supplies the nationally known Duckster, rain wear, warmth jackets and ski apparel. Penna brought a bonus: part owners Perry Como and Bob Hope who have been named "honorary members" to the Pro Golf board.

A staff of touring pros help the company by using and recommending the companies' products. Names include Jimmy Demarest, Deone Beamon and Mason Rudolph. Also making Pro Golf products is a staff of "local home pros" at the country club pro shops.

The 1,200,000 Pro Golf shares are quoted 21 over-the-counter (about 20 per cent closely held) and can be considered a business man's risk at that price for appreciation.

Mr. Whiting is account executive for Merrill Lynch, Pierce, Fenner and Smith, Inc., in Mobile, Alabama.

PHYSICIAN PLACEMENT SERVICE IN ALABAMA

The Physician Placement Service of the Medical Association of the State of Alabama is designed to assist both physicians and communities. MASA members having knowledge of practice opportunities or wishing to relocate their own practices are urged to communicate with the Placement Service. For further information: write Mr. Emmett Wyatt, Executive Assistant, Medical Association of the State of Alabama, 19 South Jackson Street, Montgomery, Alabama 36104, or Telephone 263-6441.

Locations Wanted

General Practice—

Age 44, Medical College of Alabama, 1967, seeking associate practice in town of 12,000 plus population in central or south Alabama. LW-1

Age 56, Georgetown University 1938; seeking solo, group or associate practice, with general surgery. LW-2

Age 52; University of Chicago 1950; seeking group, industrial, institutional or student health position. LW-3

Age 31, Western Reserve, 1964; seeking group, associate or institutional practice. LW-4

Age 38; University of Oklahoma, 1955; seeking associate, institutional or industrial practice; in town of 10,000 plus population; interest in surgery. LW-5

Age 28; University of Tennessee, 1965. LW-7

Age 27, Medical College of South Carolina, 1966; seeking location in Gadsden area or in southern part of state in town of 5-7,000 population; available July 1, 1971. LW-7/1

Age 38; Medical College of Alabama, 1957; seeking location in south Alabama. LW-7/2

Age 60, University of Arkansas 1932, seeking location for general or industrial practice. Available May 1969. LW-7/3

Age 42; Medical College of Alabama 1957; seeking location in central Alabama, near Montgomery. LW-7/4

Internal Medicine—

Age 36, Medical College of Alabama, 1963; seeking solo, group, or associate practice. LW-8

Age 34; Hahnemann Medical College 1959; Board eligible, National Board; seeking solo, group, or associate practice. Available immediately. LW-11

Age 35; University of Tennessee 1958; Board certified; seeking group, industrial or institutional practice. LW-12

Age 37, Duke University, 1956; Board certified, seeking group, associate, or institutional practice. LW-13

Age 33; University of Miami 1962; Board eligible; National Board; seeking solo, group practice, hospital practice, or industrial practice. Available July 1969. LW-13/1

Age 31; Medical College of Georgia 1963; seeking location for practice of internal medicine-cardiology. Available 1970. LW-13/2

Neurology—

Age 32, Medical College of Georgia, 1964, seeking assistant or associate, or institutional practice. LW-14

Age 31; Harvard 1962; Board eligible; National Board; seeking solo, group or associate practice. Available July 1969. LW-15

Age 30; Medical College of Alabama 1962; Board eligible; National Board; seeking solo, group, associate or institutional practice. Available January 1969. LW-16

Age 29, Indiana Univ., 1964; Board eligible; seeking assistant or associate practice in city of over 100,000 population; available July 1, 1969. LW-17/1

Obstetrics-Gynecology—

Age 35, Vanderbilt University, 1950. Board eligible. LW-18

Age 49, University of Nebraska, 1943; Board certified, seeking group or institutional practice. LW-19

Age 34, Medical College of Virginia, 1961, Board eligible, seeking group or associate practice. LW-20

Age 33; University of Illinois, 1964; seeking associate practice. LW-21

Ophthalmology—

Age 33; St. Louis University, 1962; seeking solo, or associate practice; available July 1, 1969. LW-21/1

Otolaryngology—

Age 32, University of Pennsylvania 1962, seeking associate practice. Available April 1970. LW-21/2

Age 35, University of Miami 1959, seeking location in city of 150,000 plus population. Available August 1970. LW-21/3

Psychiatry—

Age 52, Chicago Medical School 1939; Board eligible; seeking group or institutional practice, preferably near Gulf Coast. LW-22

Pediatrics

Age 30; Tulane University 1964; seeking associate practice in south Alabama in city of 20,000-90,000 population. Available September 1969. LW-23

Radiology

Age 28; Northwestern University 1964; completing radiology residency. Available July 1971. LW-24

Locations Wanted

(Continued)

Surgery—

Age 30; Duke University School of Medicine, 1964; seeking location in larger cities. LW-26

Age 33; University of Missouri, 1961; seeking group or associate practice. Available January 1969. LW-27

Age 38; Emory University, 1956; Board eligible, seeking group, associate, or institutional practice. LW-28

Age 37; Faculty of Medicine, Manitoba, 1957; Board certified; seeking associate or institutional practice. LW-29

Age 34; University of Santo Tomas, 1961; Board eligible, seeking group or associate practice. LW-30

Age 35; University of Santo Tomas, 1956; Board eligible, seeking solo, group or industrial or associate or institutional practice. LW-31

Age 36, Indiana University 1961; Board eligible; seeking practice in city of 100,000 plus population. Available July 1969. LW-31/1

Age 37, University of Paris 1961; seeking group or institutional practice in city of 80,000 plus population. Available July 1969. LW-31/2

Age 48; Marquette University 1943; Board eligible; seeking institutional practice in east Alabama. Available July 1969. LW-31/3

Age 48; University of Pennsylvania 1950; Board eligible; seeking solo or group practice. LW-31/4

Urology—

Age 30; Louisiana State University, 1963; Board eligible, seeking associate, or group practice. LW-32

Age 31, Chicago Medical School 1963, seeking associate practice in Montgomery. Available July 1970. LW-32/1

Physicians Wanted

Special Openings—

Specialist in the following fields: Internal Medicine, Pediatrics, Obstetrics-Gynecology and General Practitioners. 58-bed fully accredited general hospital with 91-bed addition recently completed. Modern new office space available. PW-20

Pediatrician, Internist, and ENT specialist to join a well-established group practice in a community of 40,000 in East Alabama. The community has a 125-bed accredited hospital, 32-bed extended care facility. Good transportation on interstate with quick access to metropolitan area. Will pay travel expense for interview. PW-20-1

Opportunity for ENT, Internal Medicine, and Orthopedic Surgery practitioners to join partnership at clinic located in city of 38,000 population in trade area of 150,000 population in northeast Alabama. PW-20/2

Position for full-time industrial practice at textile plant with 2,400 employees at Decatur, Alabama. PW-20/3

Internists, Board-certified or eligible. One needed now and another in 1 or 2 years. For early partnership with internist in south Alabama city of 40,000 plus population. New office building adjacent to 181-bed hospital. Practice largely hospital in-patient and Cardiology. PW-21

Opportunity for a Board certified or eligible surgeon to be associated with a Board surgeon in city of 150,000 population. PW-21/1

Opportunity for physician interested in joining a progressive public health tuberculosis control program working in Birmingham, Jefferson County. Provide outpatient medical services and some administrative duties. Fringe benefits and salary open. PW-22

Obstetrician-Gynecologist—

Excellent opportunity for a trained Ob-Gyn man who would join a three-man partnership practice in city of 30,000 population located in southwest Alabama. Salary is proposed for the first 12 months, a limited partnership to begin at the end of twelve months, and full partnership to begin at the end of 24 months. PW-25

General Practitioners—

Opportunity in town of 4,000 population in trade area of 50,000 population, located within 100 miles of two metropolitan areas in south Alabama. Industrial and farming area. 44-bed hospital. Office space and equipment available in new building with another physician. Several churches, schools, and service clubs. PW-1

For community of 1,500 population located in south Alabama near city of 12,000 population. Hospitals located within 25 miles. Office space and equipment available. Farming, cattle and textile industries in the area. Several churches and school. Civic clubs and golf courses. PW-1-1

For town of 10,000 population in county of 40,000 population located in scenic mountainous section of Northeast Alabama. Office space and equipment available. Hill-Burton hospital-nursing home. Expanding industries in top agricultural area. PW-1-2

For community of 2,000 population, plus large trade area, located in Southeast Alabama. Modern clinic, fully equipped. PW-1-3

Opportunity in port town of 1,000 plus population in population center of 10,000 located in Southeast Alabama. Clinic available. Hospital located less than 20 miles away. Recreational advantages for water sports. Expanding industrial and farming area. Churches and schools. PW-1-4

For town of approximately 1,000 population in Northwest Alabama, near Tennessee Valley waterways. New 15-bed clinic available. Centrally located near metropolitan areas. Extensive industrial developments. PW-1-5

For town of 12,500 population in trade area of 50,000 located in South Alabama. Nearest large city with population of 145,000 is 80 miles away. Two hospitals with 140 beds. Numerous small industries. Several churches and schools. Recreational activities include water sports and golf course. PW-1-6

(Continued on Page 1162)

Physicians Wanted

(Continued from Page 1161)

General Practitioner to join partnership in town of 3,000 population, plus trade area of 20,000 population in northwest Alabama. Modern office building with six examining rooms. Full partnership at beginning of third year. New 30-bed Hill-Burton hospital. Salary open. PW-1/7

Opportunity in community of 3,000 population with over 8,000 population in trade area, near metropolitan area in northwest Alabama. Clinic and office equipment available. New 400-bed hospital and older hospital, and several nursing homes. PW-1/8

For town of 2,000 population in trade area of 7,000 population located in west Alabama. Physician recently died. Nearest city is 30 miles away. Medical facilities include Hill-Burton hospital and nursing home. Churches, schools, civic clubs, and recreational advantages. PW-1/9

For town of 1,800 population located in southeast Alabama in a population center of 10,000 population. PW-1/10

For town of 7,000 population located in population center of 15,000 population located in northeast Alabama. Office space and equipment available. Hospitals located in adjoining towns within 12 miles. State University located in the town. PW-1/11

For town of 2,500 population located in northeast Alabama. 17-room modern brick clinic fully equipped. Hospital nearby. Excellent schools and recreational advantages, water sports. PW-1/12

For town of 2,500 population located in northwest Alabama. 55-bed hospital being completely renovated, and an adjoining 69-bed nursing home. PW-1/13

Opportunity for group practice in town of 10,000 population in north Alabama. PW-2

Physician wanted to join 39 year old Medical College of Alabama graduate in a well established general practice in West Central Alabama town. Salary initially followed soon by full partnership. PW-3

Opportunity in community of 5,000 population in trade area of 30,000 population located in northeast Alabama where at present time there are only two active full time general practitioners. Modern offices or clinic facilities available. 48-bed accredited hospital and 52-bed skilled nursing home adjoining the hospital. Cities of approximately 75,000 population located within 25 miles distance. Agricultural and expanding industrial area. Numerous churches and schools. Country club and golf course being developed and water sports and outdoor activities offer recreational advantages. PW-4

Physician wanted to join well established partnership in Northwest Alabama city of 15,000 population. Two accredited hospitals, junior college, schools, churches, recreational activities. No obstetrics or surgery. New office building. PW-7

For city of approximately 15,000 population in north Alabama, with trade area of approximately 45,000 population. Hospital with over 100 beds, and expansion planned for next year. Nursing homes in the area. Industrial growth and agricultural region. Several churches and schools. Golf course, civic and fraternal organizations. PW-8

For partnership practice in clinic in town of 2,000 population in area of 10,000 population located in north-central Alabama. 40-bed hospital. PW-9

For assistant or associate in clinic located in town of 10,000 population located in northeast Alabama. 65-bed Hill-Burton hospital. PW-10

For associate practice in city of 6,000 population in area of over 10,000 population located in East-central Alabama. PW-11

For solo practice in county clinic located in East-central Alabama. Office, equipment and housing available. 70-bed Hill-Burton Hospital and 22-bed nursing home. PW-12

For town in southwest Alabama, approximately 1,000 population in trade area of approximately 5,000 population, within 60 miles of large city of 35,000. Nearest hospital is located 18 miles away. Arrangements available for office space. Small industries and agriculture. Civic clubs and golf course nearby. Churches and school. PW-13

For town of 1,000 plus population in west-central Alabama in trade area of 20,000. Clinic available. Nearest city of approximately 70,000 population is located a distance of 17 miles. Farming, cattle, timber, and manufacturing plants are principal resources of the area. Churches, schools, and recreational advantages. PW-15

Opportunity for general practitioner to join a five-man group, practicing as a partnership. Each man in the group is either specialized or semi-specialized. The practice is physically located within a 70-bed hospital. Willing to pay qualified person $36,000 for the first year, with possible partnership status in one year. Would consider a physician for locum tenens for three to six months at $2,000 per month. PW-16

For town of 3,600 population in trade area of 5,000-7,000 within 100 miles of two large cities and the Gulf Coast. 50-bed hospital located in the town. Office space available. Agricultural and expanding industrial area. Several churches and two schools. Recreational activities in the town as well as nearby—golf course, hunting and fishing. PW-17

Unusual opportunity for two general practitioners with military obligations satisfied at a modern fifty bed facility located 15 minutes drive from largest metropolitan center in north-central Alabama. Construction of a new two-story office building is scheduled to begin soon. PW-18

Opportunity in city of 5,000 population located in Northeast Alabama in trade area of approximately 10,000 population. Office space available. One physician died recently. Hospital and nursing home in the city. PW-19

nursing care for cancer patients–

...a major concern for their families, *and* for their physicians. In a unique pioneering service, the American Cancer Society is deeply involved in finding a solution.

Recognizing the phenomenal growth of nursing homes—aware of the shortage of nurses—knowing the implications of the extended care benefits of Medicare—the Society has launched a dramatic educational demonstration project on cancer nursing for nursing home staff. Special emphasis is on colostomy irrigation, care of the laryngectomized patient, care of an ileal bladder, and emergency nursing. To achieve maximum application of this plan, a cadre of nurses is being trained by the Society to conduct cancer nursing courses in nursing homes throughout the nation.

This endeavor has been warmly endorsed by the American Nurses Association and other professional organizations. We feel sure that such a program, bringing skilled nursing care to the bedside of the cancer patient, will be enthusiastically received by the medical profession.

AMERICAN CANCER SOCIETY®



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An all new homelike psychiatric residence located on a lovely five-acre tract inside the city, providing a comprehensive range of services, including inpatient (28 beds), day care, and outpatient treatment. The therapeutic setting is an open community one with no provisions for locked wards. Each patient participates in an intensive treatment program consisting of individual pyschotherapy, group psychotherapy, topical small group discussions, occupational therapy and recreational therapy, and other group activities in the Center as well as in the community, depending on individual interests and needs. Drugs are used when appropriate.

Any individual may be admitted who, in the opinion of the staff, might benefit from the services provided in this particular setting. This can best be determined by a preadmission consultation with the person and a responsible member of his family.

Brochures and rate schedules are available on request.

Leonard T. Maholick, M. D.
Medical Director

Maj. Gen.(Ret.) Howard Snyder
Administrator

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Area Code 404 - 324-4882

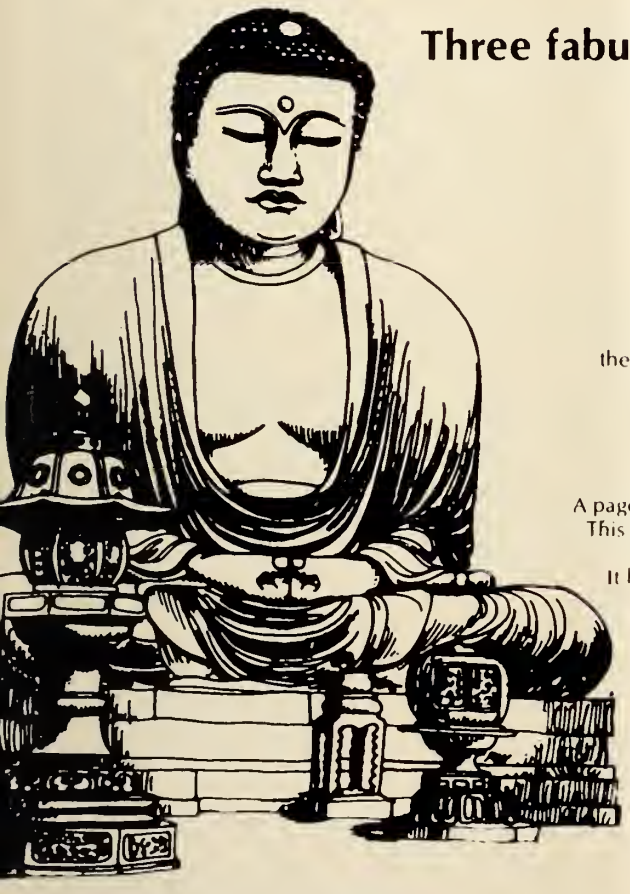
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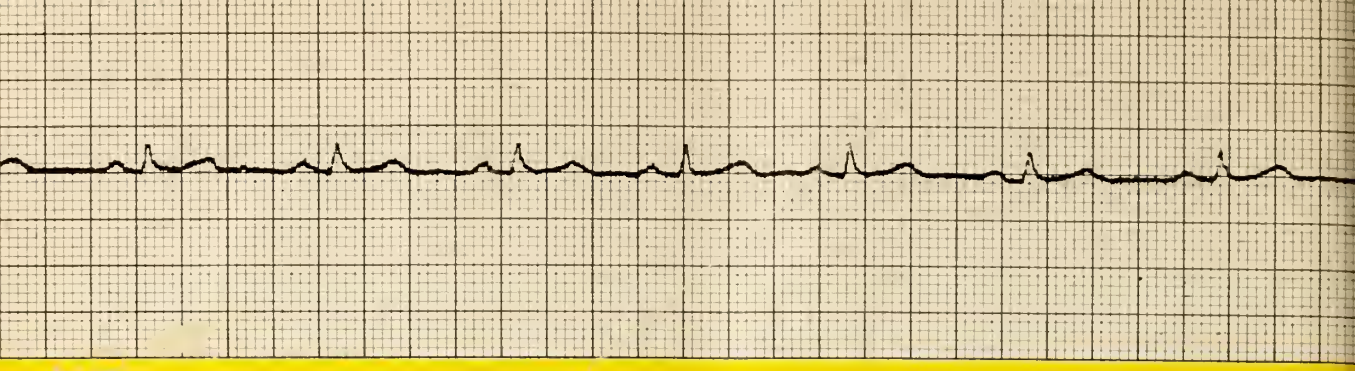
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When disease is ruled out and psychic tension is implicated

Valium® (diazepam) helps relax the patient and relieve his somatic symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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